Know Your Benefits

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A company of the Principal Financial Group

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MAGELLAN HEALTH SERVICES
Getting Better All the Time

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Positively different.

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FY 2010-2011
Maricopa County Employee Benefit Plan

Envision living "well" into the future...

Version 1 ~ July 28, 2010

Table of Contents

The information in this booklet highlights the Maricopa County Health Insurance Program (the "Program") for benefit-eligible employees and their eligible dependents. The Program is managed by the Workforce Management and Development Department, Employee Benefits Division.

This booklet is intended to provide you with information needed to make informed decisions regarding the selection of your benefits provided by the Program. There is a Glossary of Terms and a Glossary of Acronyms provided for your reference to help you understand the information.

The benefits described herein are summaries of the County's official plan documents and contracts that govern the Program. In the event of a discrepancy between the information in this booklet and the official documents, the official documents govern.

Maricopa County reserves the right to change or cancel its Program, in whole or in part, at any time.

Participation in any of the County's benefit plans provided through the Program is not a contract of employment.

How to Obtain Benefit Information

Information about the Program is available on the Internet at **www.maricopa.gov/benefits** or on the Electronic Business Center (EBC)/ Intranet at **ebc.maricopa.gov/ehi**.

Both of these Web sites are referred to as the Employee Benefits Home Page in this document.

You may also e-mail the EB Division at **BenefitsService@mail.maricopa.gov** or, for enrollment and plan information, call 602-506-1010 from 8 AM to 5 PM MST Monday- Friday or visit the EB Division located at 301 South 4th Avenue, Suite B100, Phoenix.

The EB Division can assist you with general questions related to premiums, eligibility and enrollment, status changes, and benefit continuation while on or returning from a leave of absence (LOA) and/or upon retirement.

Please contact the specific benefit vendor for answers to detailed benefit questions regarding coverage, cost and claim(s) payment. Vendor contact information is located in the "**Who to Contact**" section of this booklet.

Important Information

Carefully Read All of the Information in this Booklet

Do not make a medical or dental election solely on the basis of a healthcare provider's participation with the vendor's provider network because physicians and dentists may stop participating during the plan year. If a specific physician or dentist is very important to you, consider selecting a plan with out-of-network benefits such as an Open Access Plus (OAP) High or Low medical plan or the Choice Fund high-deductible medical plan and/or CIGNA or Delta Dental plans. Plans with out-of-network benefits allow you to use providers who do not participate with the vendor's network, at higher out-of-pocket costs.

Additionally, you should not make your pharmacy plan election solely on the basis of specific medications on the preferred medication list because medication coverage status or tier level may change during the plan year and/or some medications may start requiring prior authorization or be added to step-therapy. For example, medications may change from preferred-brand name level to non-preferred brand-name level which would cost you more; or may become available over-the-counter and therefore would not be covered under the pharmacy benefit.

When enrolling via the online Benefit Enrollment System, make your election decisions carefully as once the enrollment period (30 calendar days from event date) expires, they cannot be changed until Open Enrollment and be effective the next plan year starting on July 1. Make sure to click the "Submit" button on the Benefit Summary Page to finalize and save your elections. Once the "Thank You" page appears, your benefit enrollment is complete. More detailed instructions are found in the "**Enrollment Checklist**" section.

Print your "Confirmation Page" as verification of your elections. Keep this "Confirmation Page" to compare with the "Confirmation Statement" that will be mailed to your home address. Review your "Confirmation Statement" immediately and contact the EB Division within 30 calendar days from the date of your "Confirmation Statement", if you discover an error between the two documents. Only errors will be corrected. Your printed "Confirmation Page" from the Benefits Enrollment System will be accepted as verification of your intended enrollment elections in the event of an error.

Some plans require an election of a Primary Care Physician (PCP) or Dentist with your initial enrollment. Refer to the "**How to Look Up a Provider Online**" section.

Certain benefits require the use of your SSN. Refer to the "**Privacy**" section for more details.

Watch for your new ID cards in the mail and upon receipt, be sure to check the PCP or Dentist. Contact CIGNA or EDS to change your PCP or Dentist, if needed. If additional ID cards are needed, contact the vendor directly either by phone or through their Web site. See the "**Who to Contact**" section. Many vendors allow you to print a temporary ID card from their Web site once your enrollment information has been received from Maricopa County and processed by the vendor.

Glossary of Terms

Benefit-Eligible: A full- or part-time employee (not a temporary employee) of Maricopa County who is scheduled to work at least 20 hours per week. Contract employees may also be benefit-eligible based on the terms of their contract.

Biometric Screening Program: A program that provides employees with screenings for: Blood Pressure, Total/HDL Cholesterol and Ratio, Glucose, Height, Weight, Body Fat, Waist Circumference, and an individual Health Coaching Session that includes program referrals and health education on screening results.

Body Mass Index (BMI): A number calculated from a person's weight and height. The formula is defined as (weight in pounds*703)/(height in inches squared). For example, if your weight is 135 pounds and your height is 61 inches, your BMI is 25.50 (135*703))/(61*61).

CIGNA Care Network (CCN): A high-performing cost-effective specialty care provider network that includes the following provider specialties: Endocrinology, Allergy/Immunology, Ear/Nose/Throat, Cardiology, General Surgery, Dermatology, Gastroenterology, Hematology/Oncology, OB/GYN, Infectious Disease, Neurology, Nephrology, Ophthalmology, Orthopedics/Surgery, Rheumatology, Cardio-Thoracic Surgery, Neurosurgery, Urology, Colon and Rectal Surgery and Vascular Surgery. These providers are identified by a Tree of Life Symbol in the CIGNA provider directory. You pay a lower copay when you receive care from a specialist who has earned the CCN designation.

CMG (CIGNA Medical Group): A network of providers who are employed by CIGNA HealthCare of AZ who practice in the CMG facilities that are owned and operated by CIGNA. Primary and some specialty and ancillary care are provided at the CMG facilities. Some specialty care is provided through the OAP network when a referral is made by the CMG physician.

CMG High and Low Plan: Managed-care plans that require members to use the CMG facilities for primary and most specialty and other services. Services provided by non-network providers or providers who practice in their own offices are not covered.

Co-insurance: A cost-sharing requirement under a health insurance policy, which provides that the insured will be liable for a percentage of the costs of covered services after payment of a deductible, if applicable.

Copay: A cost-sharing arrangement in which the insured pays a specified flat dollar amount for a specific service (such as $30 for an office visit). The amount does not vary with the cost of the service, unlike co-insurance, which is based on a percentage of the cost.

Deductible(s): Under a health insurance policy, the amount required to be paid by the insured usually before benefits become payable.

Flexible Spending Account (FSA): A plan which provides employees with a way to set aside money on a pre-taxed basis to cover the costs of either health care expenses that are not covered under their health insurance coverage (medical, pharmacy, mental health, dental and vision) or dependent care expenses that enable the employee to work.

Group Insurance Qualified Status Change Form: A form provided by the Employee Benefits Division on which the employee requests to add or drop dependents due to a qualified status change.

Health Assessment (HA): A brief online questionnaire that analyzes the health risks of the employee.

Health Coaching Program: A program where Health Coaches work one-on-one with employees to help them identify and meet health goals.

Health Maintenance Organization (HMO): HMOs offer comprehensive health coverage for both hospital and physician services. An HMO contracts with health care providers, (physicians, hospitals and other health professionals), who participate in their network. The members of an HMO are required to use participating network providers for all health services, and many services must meet further approval by the HMO through its utilization review program. HMOs are the most restrictive form of managed care benefit plans because they manage and restrict the procedures, providers and benefits.

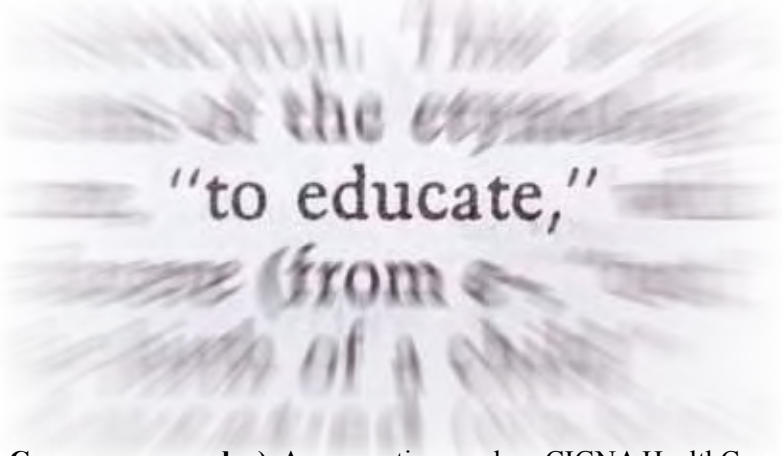
Health Plan: Includes medical, pharmacy, vision, behavioral health and substance abuse, and dental coverage.

Health Savings Account: A tax-exempt account established exclusively for the purpose of paying qualified medical expenses of the account beneficiary who, for the months for which contributions are made to an HSA, is covered under a high-deductible health plan.

High Option: A plan where premiums are higher than a low option plan because the insured shares less of the costs with lower copays.

In-Network (or Network, Participating Provider): Health care provided by a doctor, hospital, pharmacy or other health care provider with whom the plan has contracted to provide services at specified fees.

Insured (aka Member): A person or organization covered by an insurance policy.



Insurer (Insurance Company or vendor): A corporation, such as CIGNA HealthCare of Arizona, engaged primarily in the business of furnishing insurance to the public.

Low Option: A plan where premiums are reduced in comparison to a high option plan because the insured shares more of the costs in the form of higher copays and co-insurance.

Medical Package: Includes coverage for the medical, behavioral health, substance abuse, vision, wellness and pharmacy plans.

Medical Waiver Payment: Compensation paid to the employee by the County if medical coverage is not elected because of enrollment in other eligible group health insurance. Waiving medical coverage means waiving coverage for all components of the medical plan, which includes medical, vision, pharmacy, wellness and behavioral health and substance abuse benefits.

OAP (Open Access Plus) High or Low Plan: A plan that gives options to use a network or non-network provider each time the insured needs medical care, and does not require a referral to see a specialist.

OAPIN (Open Access Plus) In-Network: A plan that uses a network of providers who practice in their own offices and independently contract with CIGNA. Non-network providers are not covered under this plan. The OAP In-Network also includes the CMG network. A referral is not required to see a specialist.

Out-of-Network (or Non-Participating, Non-Network Provider): Health care received from a provider who is not contracted with the insured's health plan network.

Out-of-Pocket Maximum: The maximum amount the insured pays each year for health care. The maximum may apply only to specific services such as inpatient hospitalizations. After this share of eligible expenses has reached the plan's out-of-pocket maximum per person or per family, the plan pays the full cost of eligible expenses for the rest of that plan year. The out-of-pocket maximum does not include any copays, pharmacy or mental health/substance abuse treatment expenses, or non-certification penalties. Each summary plan description lists the expenses that count towards the out-of-pocket maximum.

Plan Year: July 1 through June 30.

Preferred Medication List (aka Formulary): List of prescription drugs approved by a pharmacy benefit manager. Drugs on the preferred medication list are generally more cost effective and are as effective as other drugs that are non-preferred in the same therapeutic medication class. The list is available on the Employee Benefits Home Page under the pharmacy tab.

Preventive Care Services: This includes all routine preventive services such as Well Baby Care, Well Child Care and Adult Preventive Care as identified by each plan in the plan summary.

Primary Care Physician (PCP): A physician who practices general medicine, family medicine, internal medicine or pediatrics.

Reasonable and Customary Charge (R&C): The prevailing charge of most other providers in the same or similar geographic area for the same or similar service. If the insured receives out-of-network services and the provider's fee is more than the R&C charge, the insured will have to pay the amount of charges above R&C. When care is received from an in-network provider, the eligible expenses are determined from the network provider's contracted rate.

Short-Term Disability (STD) Benefits: STD pays a percentage of the insured's salary for up to 23 weeks after a 3-week waiting period if he/she becomes temporarily disabled due to sickness or injury and is not able to perform the essential functions of his/her job. The insured must be under the regular care and treatment of an appropriate provider.

Specialty Medication: Usually expensive drugs (oral or injectable) that are used to treat complex and rare medical conditions. These drugs may require special care and handling (such as refrigeration) and patient counseling due to their high risk of causing serious side effects or complications.

Sub-Acute Facilities: A hospital-based facility or a freestanding facility that provides lower level of care than acute care.

Term Life Insurance: Term life insurance covers a person for death benefits for a limited time (a term). In the case of the term life insurance coverage provided by The Standard, the term is conditional. You are covered as long as you are employed by Maricopa County. Term life insurance does not have any cash value.

Glossary of Acronyms

Abbreviations used throughout this booklet

AD&D: Accidental Death & Dismemberment

ADP: Automatic Data Processing, Inc.

AHCCCS: Arizona Health Care Cost Containment System

ARS: Arizona Revised Statutes

ASRS: Arizona State Retirement System

BMI: Body Mass Index

CCN: CIGNA Care Network

CMG: CIGNA Medical Group

COBRA: Consolidated Omnibus Budget Reconciliation Act

EAP: Employee Assistance Program

EB: Employee Benefits

EBAC: Employee Benefits Advisory Council

EBC: Electronic Business Center (Intranet)

EDS: Employers Dental Services

EE: Employee

EOI: Evidence of Insurability

FML: Family Medical Leave

FMLA: Family Medical Leave Act

FSA: Flexible Spending Account

GIA: Guarantee Issue Amount

HA: Health Assessment

HDL: High-density lipoprotein

HIPAA: Health Insurance Portability and Accountability Act

HICN: Health Insurance Claim Number

HMO: Health Maintenance Organization

HR: Human Resources

HSA: Health Savings Account

ID: Identification

IRC: Internal Revenue Code

IRS: Internal Revenue Service

LOA: Leave of Absence

MH: Mental Health

MST: Mountain Standard Time

MWP: Medical Waiver Payment

NAIC: National Association of Insurance Commissioners

NEO: New Employee Orientation

NP: Non-Preferred

NRS: Nationwide Retirement Solutions

OAP: Open Access Plus

OAPIN: Open Access Plus In-Network

OE: Open Enrollment

PCP: Primary Care Physician

PHI: Protected Health Information

PML: Preferred Medication List

PPO: Preferred Provider Organization

PRISM: Payroll, Records, Information, Staffing & Management

PSPRS: Public Safety Personnel Retirement System

PST: Pacific Standard Time

RIF: Reduction in Force

Rx: Prescription

SPD: Summary Plan Description

SSN: Social Security Number

STD: Short-Term Disability

UV: Ultraviolet

WHI: Walgreens Health Initiative

Introduction

Maricopa County recognizes your valuable contributions as an employee by offering comprehensive benefits for benefit-eligible employees and their eligible dependents through the Employee Health Insurance Program. Maricopa County is committed to helping you manage the high costs of health care, the risk of lost income due to illness and disability, and the need to prepare for a secure retirement. The County's program provides:

Health, Life, Disability Plans & Flexible Spending Accounts

- A choice of six medical plans;
- A choice of three pharmacy plans;
- A vision plan;
- A choice of two behavioral health and substance abuse plans;
- A choice of three dental plans;
- Basic and additional life, basic and additional accidental death and dismemberment, and dependents (spouse and child) life plans;
- A short-term disability (STD) plan; and
- Health care (general and limited use) and dependent care flexible spending accounts.

Other Programs and Services Include:

- An employee assistance plan (EAP);
- A deferred compensation plan;
- Discounts on auto, home and renters insurance;
- A group legal plan;
- Arizona State Retirement System (ASRS) retirement plan, which include a long-term disability benefit, or Public Safety Personnel Retirement System retirement plan. If you meet the retirement system's eligibility criteria, you must be enrolled in and contribute to the applicable retirement plan.

Eligibility

Who's eligible?

You can participate in the health, life, and disability plans and the flexible spending accounts if you are a regular employee (except some contract employees as specified below) scheduled to work at least 20 hours per week.

For benefit plan purposes, "regular employee" is defined as a full-time or part-time employee who is not temporary, but who may be a contract employee. (When related to benefits administration, the definition herein of a regular employee differs from that which is used in the Merit Rules, available online at **http://ebc.maricopa.gov/pp/hr/tocs/EmpMerit_TOC.asp**.)

Employees working under specific contracts may or may not be eligible for benefits based on the terms of their contract. Contract employees may be offered health insurance benefits at the option of the appointing authority as long as the employee meets the same eligibility requirements of classified and unclassified employees. Contract employees scheduled to work less than 20 hours per week will not qualify for benefits, except in the following circumstance:

> Employees who retire from the ASRS are statutorily limited to the number of hours they may work for the first year following their retirement date. If one of these retirees returns to work within that time period, he/she may be offered only part-time benefits, regardless of the number of hours he/she is scheduled to work. This is at the option of the appointing authority, while the employee waits for the one year limitation on hours worked to expire. At that time, the employee shall revert to meeting the requirements of all other contract employees.

Regular employees who are scheduled to work less than 20 hours per week, all temporary employees, and contract employees whose contract specifies they are not benefit eligible are ineligible to participate in the health, life, disability plans, group legal plan and the flexible spending accounts.

Are dependents eligible?

Your legal spouse as defined by AZ statute (does not include common-law, domestic partner, or significant other) and/or your unmarried dependent child(ren) are eligible for coverage under your health plans and/or dependents life and family accidental death and dismemberment insurance plans. Dependent child(ren) must meet the IRS definition of dependent children pursuant to IRC Section 152 and Maricopa County's definition and eligibility requirements below.

The term "child" means your unmarried natural child, stepchild, legally adopted child, child placed with you for adoption or child for whom you have been awarded legal guardianship. The term "dependent" means a child who meets one of the relationships listed above, and who meets the following criteria.

Dependent child(ren) under 19 or under 25 (if full-time student) is subject to all of the following:

1. Must be unmarried;
2. Must reside with you for more than one-half of the tax year (January – December);
   a. Temporary absences due to school attendance do not violate this residency rule.
   b. Qualified Medical Child Support Orders or other court/administrative orders do not violate this residency rule.
3. Must be under age 19, or a full-time student and under age 25, or any age if permanently and totally disabled;
   a. For a child 19 or older, to be deemed a full-time student, the school he/she attends must be an educational organization defined in Code §170(b)(1)(A)(ii) that includes elementary, junior and

senior high schools, colleges, universities, and technical, trade and mechanical schools. It does not include on-the-job training courses, correspondence schools, or schools offering courses only through the Internet. People who work "co-op" jobs in private industry as part of a school's regular course of classroom and practical training are considered full-time students. The child must be attending on a full-time basis except when on a medically necessary leave of absence of one year or less. The school will define and determine full-time student status.

b. For a child who is permanently and totally disabled, the child must have been medically certified as permanently and totally disabled prior to his/her 19th birthday (or prior to his/her 25th birthday, if disability began while a full-time student).

4. There is no earning income limit for the dependent child.

Additional rule for dependent child(ren) age 19 or under age 24 and a full-time student

The child must not have provided more than one-half of his/her support during the tax year (January – December).

Additional rule for dependent child(ren) age 24, but under age 25 and a full-time student

The child must not have received more than one-half of his/her support during the tax year (January – December) from the employee.

Verification of continued eligibility as a student or disabled child

You are responsible for ensuring that only eligible dependents are enrolled in your health plan and for immediately notifying the EB Division when your dependents become ineligible. You will be liable and responsible for the cost of all claims and administrative costs paid or incurred for your ineligible dependents beginning with the end of the pay period in which the dependents became ineligible. Additionally, failure to notify the EB Division within 60 calendar days of ineligibility forfeits the dependent's right to COBRA continuation coverage.

You must provide verification of continued eligibility of your dependent as a full-time student to the Dependent Audit Services Division of ADP when your dependent is within 60 days of turning 19 and for the Fall and Spring semesters. Supporting documents to verify continued eligibility will be requested by a letter that is mailed to your home address. You must respond to the letter within 30 calendar days. To respond, complete and sign the enclosed cover sheet and either fax or mail the cover sheet and the supporting documents to the Dependent Audit Service Center. Refer to the "**Who to Contact**" section for contact information. The Dependent Audit Service Center will send a response to your home address regarding the approval or denial of coverage as a result of the audit. Dependents that do not pass the audit will be dropped retroactively to the end of the pay period in which they lost eligibility.

Acceptable documentation includes enrollment forms from school, school letters showing full-time student status, registration confirmations, bursar's letters, and mission call letters with start and end dates. For full-time students who are temporarily unable to attend school on a full-time basis for up to one year, in compliance with Michelle's Law, a doctor's letter of medical leave of absence with dates of injury or illness is acceptable documentation.

Full-time students are eligible through the summer as long as they enroll and attend classes through the Fall semester on a full-time basis. Should your child not return to full-time student status for the Fall semester, or enroll but not complete the Fall semester classes, the child will be deemed retroactively ineligible on the last day of the pay period following the child's last day of school attendance.

If your child is disabled and 19 or older, CIGNA will request verification of disability at frequencies determined by the type of disability.

Coverage and Enrollment

When does coverage begin for newly eligible employees?

You have 30 calendar days from your event date (date of hire for a newly hired employee, effective date of employee going from a benefit ineligible status to a benefit eligible status or date of hire for an elected official) to select and submit your benefit elections online through the Benefit Enrollment System at **https://portal.adp.com**. To prevent a retroactive premium adjustment to your paycheck and to preserve your choice of benefits, online enrollment should be completed and submitted as soon as possible within the 30-day period. Refer to the "**Enrollment Worksheet Example**" and the "**Enrollment Checklist**" sections for details.

Premium starts accruing on the first day of the pay period that includes your coverage effective date and is not pro-rated.

New Hire or Rehire

Benefit coverage for a newly hired employee begins the first day of the month following the date of hire, except for FSA coverage, if the election is made after the first day of the month following date of hire, coverage begins on the date he/she submits his/her elections. Life insurance becomes effective at different times depending on whether it is contributory or non-contributory, if EOI is required, and if the application is made outside of the 30-day enrollment period. Benefit coverage for a re-hired employee with a break of employment of less than 30 calendar days begins the first day of the pay period following benefit termination, so that there is no gap in coverage.

Benefit Ineligible to Benefit Eligible Status

Benefit coverage for an employee whose change in employment status renders him/her benefit eligible, such as going from temporary status to regular status, begins the first day of the month following the status change, except for FSA coverage, if such election is made after the first day of the month following the status change, coverage begins on the date he/she submits his/her elections. Life insurance becomes effective at different times depending on whether it is contributory or non-contributory, if EOI is required, and if the application is made outside of the 30-day enrollment period.

Automatic Enrollment

If you do not complete enrollment online through the Benefit Enrollment System within 30 calendar days of your newly eligible or new hire or rehire date, you will be automatically enrolled in the CIGNA Choice Fund high-deductible medical plan for employee only coverage as a tobacco user and as not participating in Biometric Screening and the Health Assessment incentives. Your basic life insurance coverage will be one times your annual salary rounded up to the next thousand to a maximum of $500,000. Your coverage will be effective as explained in the "**New Hire or Rehire**" or "**Benefit Ineligible to Benefit Eligible Status**" sub-sections above. However, if you were employed by Maricopa County, terminated employment and then were re-hired within 30 calendar days, the benefit elections in place before your termination will be reinstated, with no option of changing your elections.

If you do not want to be automatically enrolled, you must decline (waive) coverage through the Benefit Enrollment System within the aforementioned 30-day period.

Can I change my benefits once I've submitted my benefit elections in the Benefit Enrollment System?

For new hire or newly eligible events, you may change your benefits during the enrollment period (30 calendar days from event date). Once the enrollment period expires, changes to your benefit elections or to the automatic enrollment will not be allowed until the next Open Enrollment period.

Decreases to additional life insurance, additional AD&D and dependents life insurance are allowed at any time. Application for increases to additional life insurance may be made at any time, as long as EOI is provided, but the increase is subject to the approval by the life insurance company.

Open Enrollment occurs at times designated by the EB Division. The next open enrollment will be April, 2011 with benefit elections being effective on July 1, 2011. Open Enrollment dates are posted in advance on the EBC/Intranet and communicated to each department via **e*Nouncements**. An Open Enrollment Worksheet will be mailed to your home address prior to the beginning of the next Open Enrollment, providing you with enrollment details.

If you have a qualified status change as defined under the IRC Section 125 during the plan year, certain changes are allowed. These are explained in the "**When Can Changes be Made & When Are They Effective?**" section and "**What is a qualified status change?**" sub-section.

Waiving Insurance Coverage

Waiving the Medical Insurance Package

If you do not wish to enroll in coverage under the County's medical insurance package, you must waive (decline) coverage under the County's plan by submitting your request within the enrollment period via the Benefit Enrollment System when newly eligible or on a Group Insurance Qualified Status Change Form at the time of a qualified status change. Failure to submit your request to waive coverage during your new hire/newly eligible enrollment period will result in automatic coverage as explained in the "**Automatic Enrollment**" sub-section above. Refer to the "**Important Information**" section regarding the time limitation for correction of enrollment errors.

If you elect to waive the medical insurance coverage, you relinquish County medical package coverage during the current plan year, which includes medical, behavioral health, substance abuse, vision, wellness and pharmacy benefits. However, Maricopa County offers stand-alone vision, dental, EAP and/or additional life insurance to employees who elect to waive the medical insurance package.

Should you decide to waive coverage under the County's medical package because you are covered under other eligible medical insurance, you may qualify for taxable compensation. However, employees may waive enrollment in the County's medical package (even if they are not covered by other eligible medical insurance) and opt not to receive the compensation for waiving.

Compensation for Waiving the Medical Insurance Package

The County will compensate you, through a Medical Waiver Payment (MWP), $50.00 the first and second paychecks of each month, if you are a regular employee scheduled to work at least 30 hours a week, or if you are a contract employee with full-time benefits, and you waive the medical insurance package coverage because you have coverage under other eligible medical insurance. However, the MWP is not available to Judges of the Maricopa County Superior Court who enroll as the insured in the State of Arizona's employee benefit plan.

In no case is a MWP made for the third paycheck of the month or when you do not have payable hours reported during an eligible pay period.

In order to waive the medical insurance package and receive the MWP, you must provide proof that you are covered under other eligible medical insurance such as your spouse's plan, an individual policy, or Medicare. **(Coverage under the Arizona Health Care Cost Containment System (AHCCCS) does not qualify as eligible medical insurance coverage and therefore does not qualify you to receive the MWP.)**

Proof must be submitted to the EB Division, when you initially waive the County's medical package or if you waive benefits as a result of a qualified status change, within 30 calendar days of your benefit effective date or status change, in order to receive the MWP as of the effective date. Proof submitted after 30 days will be processed on a prospective basis without a refund for any missed payments.

The MWP expires annually or when you experience a qualified status change and elect County medical coverage. Proof must be submitted annually by June 1 for the next plan year to continue receiving the MWP without a break in payment. Proof submitted between June 2 and June 30 will be processed as soon as possible without loss, but there may be a temporary break in payment due to the time needed for processing. Proof submitted July 1 or thereafter will be processed prospectively without a refund for any missed MWPs.

Proof must identify you as a covered member and include the name of the primary insured, the insurance company's name, address, and phone number, group name and number, member identification number and

coverage effective date. Complete the "Verification of Insurance Form for Medical Waiver Payment" and mail or fax this information and a copy of your insurance card to the EB Division. The form is located on the EB Home page on the EBC under the "Looking for a Form?" area, then under "General Forms". Click on the link for the "Medical Waiver" form.

You are responsible for reviewing your paycheck to verify that the MWP is provided.

If you waive the medical insurance package and timely submit the "Verification of Insurance Form for Medical Waiver Payment" but do not receive the MWP due to an administrative error, you must notify the EB Division in writing within six months from the date the error began to receive the unpaid MWP. Administratively caused MWP errors about which the EB Division is not notified in writing within six months will be corrected on a prospective basis only, and you will not receive retroactive MWP.

Waiving Other Insurance Coverage When Newly Eligible

You may elect to waive any or all of the following when you are newly eligible. However, enrollment into the plans following your initial eligibility date is limited.

Short-term Disability: You must wait until the next scheduled Open Enrollment to elect coverage regardless if you have a qualified status change.

Dental Insurance: You must wait until the next scheduled Open Enrollment period to elect coverage, unless you experience a qualified status change that is consistent with the need for dental coverage. Refer to "**What Coverage Changes Can I Make During the Plan Year?**" section.

Additional Life: You may elect this coverage up to the Guarantee Issue Amount (GIA) without providing EOI, if you experience a qualified status change. Additionally, you may increase your coverage by one level during Open Enrollment without providing EOI. You may also apply for this coverage at any time during the plan year, but EOI will be required. See "**Additional Life and Additional Accidental Death and Dismemberment (AD&D) Insurance**" sub-section in the "**Life Insurance Plan**" section for details regarding EOI requirements.

Dependents Life: You may elect this coverage up to the Guarantee Issue Amount without providing EOI, if you experience a qualified status change. You may also apply for this coverage at any time during the plan year, but EOI will be required. See "**Dependents (Child and Spouse)LifeCoverage**"sub-section in the "**Life Insurance Plan**" section for details regarding EOI requirements.

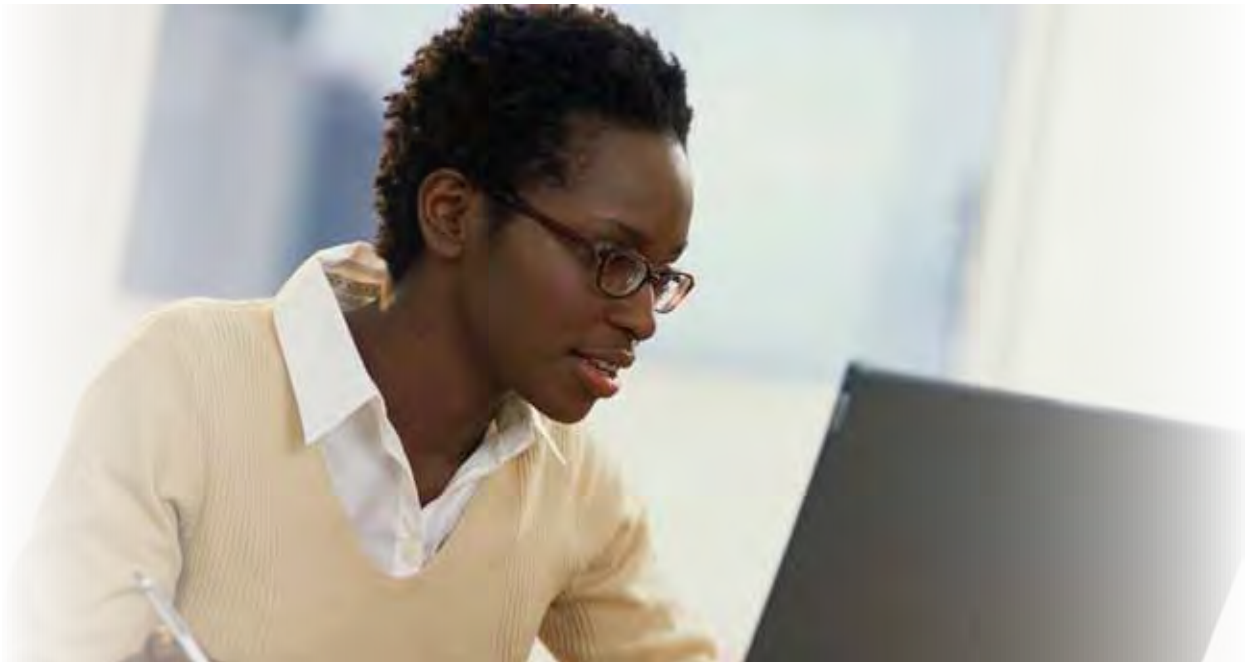
Flexible Spending Accounts: You must wait until the next scheduled Open Enrollment to elect coverage, unless you experience a qualified status

change. You may revoke your old election and make a new election, provided that both the revocation and new election are because of and correspond with the change in status. As a general rule, an election change will be found to be consistent with a change in status event if the event affects eligibility for coverage under the plan. A change in status affects eligibility for coverage if it results in an increase or decrease in the number of dependents who may benefit under the plan. In addition, you must also satisfy the following specific requirements in order to alter your election based on the change in status:

- **Gain of Coverage Eligibility under Another Employer's Plan**
  For a change in status in which you, your spouse, or your dependent gain eligibility for coverage under another employer's benefit plan as a result of a change in your marital status or a change in your, your spouse's or your dependent's employment status, your election to cease or decrease coverage for that individual under the plan would correspond with that change in status only if coverage for that individual becomes effective or is increased under the other employer's plan.
- **Dependent Care FSA**
  You may change or terminate your election only if (1) such change or termination is made because of and corresponds with a change in status that affects eligibility for coverage under the plan; or (2) your election change is because of and corresponds with a change in status that affects the eligibility of dependent care assistance expenses for the available tax exclusion.

  Example: Employee Mike is married to Sharon, and they have a 12 year-old daughter. The employer's plan offers a dependent care FSA plan as part of its Program. Mike elects to reduce his salary by $2,000 during the plan year to fund dependent care coverage for his daughter. In the middle of the plan year when the daughter turns 13 years old, however, she is no longer eligible to participate in the dependent care FSA. This event constitutes a change in status. Mike's election to cancel coverage under the dependent care program would be consistent with this change in status.

Refer to the "**What Coverage Changes Can I Make During the Plan Year?**" section.



How To Enroll When You're Newly Eligible

You should attend a New Employee Orientation (NEO) meeting to receive Program information. You must complete your enrollment within 30 calendar days of your new hire or newly eligible event date online through the Benefit Enrollment System accessed through **https://portal.adp.com**. Instructions for online enrollment are provided in the "**Enrollment Checklist**" section. It is in your best interest to complete and submit your online enrollment as soon as possible. Refer to the "**When Does Coverage Begin for Newly Eligible Employees?**" section for more information.

If you are not scheduled to attend an NEO meeting, you have the following additional enrollment options:

1. Ask your department's HR Liaison for enrollment information.
2. Go online to the EB Home page to obtain the benefit plan information you need to make your choices.
   a. The EBC/ Intranet address is: **http://ebc.maricopa.gov/ehi**
   b. The Internet address is: **http://www.maricopa.gov/benefits**
3. Contact the EB Division via Outlook e-mail at **BenefitsService@mail.maricopa.gov**.
4. Call the EB Division for information at 602-506-1010.
5. Visit the EB Division at 301 S. 4th Ave., Suite B100, Phoenix, AZ 85003.

Who Pays For Benefit Coverage?

Employer Contribution

Maricopa County makes a generous contribution toward the cost of your medical and dental plans. You have the option of selecting medical coverage from CIGNA, pharmacy coverage from Walgreens Health Initiatives (except for the Choice Fund medical plan that has pharmacy coverage through CIGNA), and dental coverage from one of three dental vendors: Employers Dental Services (EDS), Delta Dental or CIGNA Dental. The medical plans are described in the "**Medical Plans**" section and the dental plans are described in the "**Dental Plans**" section.

If you are an active regular employee scheduled to work 30 or more hours per week or a contract employee with full-time benefits, you will receive the maximum Maricopa County contribution toward the total premium (your cost) for the medical package (medical, vision, pharmacy, and behavioral health) and for either the Delta or CIGNA dental plan for you and your eligible dependents. You will pay the "Full-time Employee Premium".

If you are an active regular employee scheduled to work 20 to 29.99 hours per week or a contract employee with part-time benefits, you will receive a lower Maricopa County contribution toward the total premium for the medical package and for either the Delta or CIGNA dental plan for you and your eligible dependents. You will pay the "Part-time Employee Premium".

If you are an active regular employee scheduled to work at least 20 hours per week or a contract employee with benefits, the County contributes the same amount toward the total premium for the EDS plan.

Note: It is the department's responsibility to ensure that the employee's job record displays the appropriate number of scheduled hours and that applicable time is reported for payroll processing each pay period, even if the employee is on an unpaid leave of absence, in order for the employee premium and employer contributions to be calculated and paid or deducted correctly.

Employee Contribution

Deductions for the medical package (medical, vision, pharmacy, and behavioral health), dental and health care and/or dependent care FSAs reduce your taxable income, thus saving you money that would otherwise be paid in taxes. This tax advantage is provided under and follows the provisions of IRC Section 125.

When you elect benefits initially and during Open Enrollment (including passive Open Enrollments), you authorize the County to deduct the current employee benefit premiums or contributions from your paycheck for each benefit plan you elect, and from any applicable Short-term Disability payments you might receive in the future. Payroll deductions will be made from the first two paychecks of each month, 24 paychecks per year. However, since there are 26 paychecks per year, two paychecks have no benefits deductions, with the exception of flexible spending accounts; employee contributions to their health savings account (associated with the CIGNA Choice Fund medical plan); auto, home and renters insurance; and if you have a balance due in arrears for any benefit payments. In these instances, deductions are taken every paycheck.

You are responsible for reviewing your paycheck to verify that the correct premium deduction amounts are taken for the benefit plans you elected and the correct Wellness incentive amounts are given for the incentives in which you participated. Please refer to the "Per Pay Period Premiums" tables for each benefit elected and compare these rates to the deductions on your paycheck.

If the premium deductions and incentives on your paycheck are incorrect in that you have been charged a higher amount due to an administrative error, and you identify the problem in writing to the EB Division within six months from the date the error began, your premiums will be adjusted retroactively to reflect the correct amounts. Incorrect premium deductions resulting from you not notifying the EB Division within 30 calendar days to remove an ineligible dependent will not be refunded to you until a full claims audit has been conducted to determine liability. Administratively caused premium errors discovered after six months will be corrected on a prospective basis with no refund on the overpaid premium.

Regardless of when an error is discovered, if your premium deduction is incorrect in that you have been charged a lower amount than you should have paid, your premiums will be adjusted retroactively to the date of the occurrence and you will be responsible for the cost of the underpaid premiums.

Do Benefits Continue While on an Upaid Leave of Absence?

General

When you take an approved unpaid leave of absence (LOA) (e.g. personal, medical or military leave) from your position, your benefits will continue for a designated period of time, depending on the type of leave. See the applicable sub-sections below for details. Since going on an unpaid leave of absence is a qualified status change, you may elect to revoke (drop) some or all of your benefits during your leave. See the "**Discontinue Benefits While on LOA**" sub-section below.

Military Leave

If you are going on military leave, refer to the Military Leave policy HR2417 available online at **http://ebc.maricopa.gov/pp/hr/pdf/h2417.pdf**. This policy requires you to complete a "Notification of Uniformed Service" form indicating your intention to waive or continue benefits. Contact your department's HR Liaison to obtain this form. Complete and return this form to your HR Liaison, who will send it to Employee Records. If this form is not completed, your benefits will terminate effective with the end date of the pay period in which your unpaid leave begins. Before the military leave begins, it is advisable that you work with your HR Liaison to update your contact information such as your address and phone number and provide a person's name and phone number who may be contacted in your absence.

Subject to and in conformance with Military Leave Policy HR2417, USERRA and 10 U.S.C. § 1071 et. seq, employees who are members of the uniformed services have the option of obtaining medical and dental benefits for themselves and their dependents through the military health care system or may choose to continue their health and other benefits through Maricopa County's Program at the active employee premium rate for a period of one year to begin when the employee is placed on Leave Without Pay after the commencement of active duty. To continue coverage, the employee must notify the EB Division within 30 calendar days of the start of his/her unpaid leave and complete the "Notification of Uniformed Service" form.

Upon conclusion of the one year coverage period, the employee is entitled to continue coverage through the Program for an additional six months with the employee paying the entire cost of the premiums. Following this 18-month period, a COBRA notice will be mailed to the employee at his/her address on file with Employee Records.

Life Insurance

Your Basic Life and Basic Accidental Death and Dismemberment insurance and your Additional Life and Additional Accidental Death and Dismemberment insurance will continue in force while you are on an approved unpaid LOA as follows:

- If you are not working due to injury, sickness, or pregnancy, or if you are on a military leave of absence you will continue to be covered through the end of the pay period following 180 days from the date your approved, unpaid leave status began. You are responsible for any applicable premium during the LOA. If you are totally disabled, you may qualify for waiver of premium. Refer to the "**Life Insurance Plan**" section for details.
- If you are on an approved personal leave of absence, you will continue to be covered through the end of the pay period following 90 days from the date your approved, unpaid leave of absence began. You are responsible for any applicable premium during the LOA.

If your leave extends past the coverage end date above and you wish to continue your Basic and/or Additional Life coverage, you may qualify for portability or conversion coverage for yourself at a higher premium rate. You will be notified by a postcard sent to your home address on file with Employee Records by the life insurance vendor.

Discontinue Benefits While on Unpaid LOA

If you do not wish to continue some or all of your benefits, you must revoke (drop) coverage by completing a "Group Insurance Qualified Status Change" form within 30 calendar days of the beginning date of your unpaid LOA. However, your STD coverage may not be revoked, unless you are part of a Reduction in Force (RIF) or you are on Military Leave. Contact the EB Division or go online to **http://ebc.maricopa.gov/ehi** to the "Looking for a Form?" link to obtain the "Group Insurance Qualified Status Change" form.

If you revoke benefits, refer to the "**Return from LOA/Reinstatement of Benefits**" sub-section for information on what process and time frame to follow in order for benefits to be reinstated upon your return to work.

Length of Time Benefits May Be Continued on Unpaid LOA

If you want to continue your benefit coverage while on an unpaid LOA, you do not need to take any action, except for a Military LOA as explained in the sub-section above. However, depending on the type of leave, the period for which you are eligible to continue benefits at the employee premium rate is limited to the following:

Approved Personal LOA: up to three months of premiums (6/24ths of the annual premium) in a rolling 12-month period starting the first day of the pay period of your unpaid leave.

Approved Medical LOA: up to six months of premiums (12/24ths of the annual premium) in a rolling 12-month period starting the first day of the pay period of your unpaid leave.

Note: County (employer) contributions toward your medical and dental premiums may not extend beyond six months (12/24ths of the annual premium) in a rolling 12-month period by combining a personal leave with a medical leave.

Note: If you do not return to work after your FMLA leave entitlement has been exhausted or expires, **in certain situations the County may recover from you** the portion of medical and dental premiums it paid on your behalf while you were on such LOA, in accordance with federal regulations 29 CFR 825.213.

Premium Payment While on LOA

The department has the responsibility to report your applicable leave without pay hours each pay period. This ensures that the employer portion of the premium continues to be collected from the department and that the employee portion of the premium or contribution goes into an arrears account. Arrears account balances are paid back through payroll deduction (the value equal to one pay period's deductions) when the employee returns to work. See the exception to this process in the Note below.

Note: If you are receiving short-term disability (STD) benefits, your payments for benefit premiums will be deducted from your STD payments on a pro-rated daily rate. For example, if your per pay period premium for your medical plan is $28, this amount will be divided by 14 to determine the daily rate ($28/14 = $2). If the STD payment is for seven days, then the daily rate will be multiplied by seven and deducted from the STD payment ($2x7 = $14). The amount collected from the short-term disability payment will eventually offset the amount in your payroll benefits arrears account upon receipt of the monthly deduction report from the STD vendor.

If you terminate employment and you owe premiums, you will be notified and given an opportunity to complete a Payment Agreement and pay the past-due premiums. If you fail to respond to the notification and pay what you owe, you will be sent to collections. You are liable and responsible for the costs of all claims and administrative costs paid or incurred by you and your dependents after your benefit termination effective date, unless you enrolled in COBRA coverage following your termination.

Continuation of Coverage Beyond County Benefit Eligibility

If you continue on an approved unpaid LOA beyond the point at which the County's contribution ends or if you terminate or resign employment (either voluntarily or involuntarily), you may be eligible for continuation of coverage under the COBRA of 1985. See "**When Does Coverage End?**" section below and the "**Notifications**" section.

If you are receiving a payment under the STD benefit at the time the County's contribution ends or if you terminate or resign employment, your premium for STD coverage will continue to be deducted from your STD payment throughout your disability period.

Refer to the "**Life Insurance Plan**" section for conversion or portability coverage continuation information.

Return from LOA/Reinstatement of Benefits

If coverage is terminated because of loss of benefit eligibility or benefit revocation during your LOA, coverage may be reinstated upon your return to benefit-eligible active employment status if you complete a "Group Insurance Qualified Status Change" form within 30 calendar days of returning from leave. Failure to complete a "Group Insurance Qualified Status Change" form within the 30-day period will result in loss of benefits for the remainder of the plan year. Refer to the "**When Can Changes Be Made & When Are They Effective?**" section.

When Does Coverage End?

Coverage ends the last day of the pay period in which you and/or your covered dependents cease to be eligible (for example, if an employee terminated or retired in the middle of a pay period, or an elected official's term ended mid-pay-period, coverage would end at midnight of the last day of that pay period). However, in the case of death, coverage ends the day following the date of death.

You are responsible for notifying the EB Division within 30 calendar days when a dependent is no longer eligible. Refer to the "**Are dependents eligible?**" sub-section for details. **When coverage ends, you are liable and responsible for the cost of all claims and administrative costs paid or incurred by you and your dependents after the last day of coverage. Additionally, you and/or your dependents will lose eligibility to continue coverage under COBRA if notice of ineligibility is not received within 60 calendar days.**

If you and/or your covered dependent(s) ceases to be eligible for the medical package (including medical, pharmacy, vision and behavioral health), dental insurance or the Health Care FSA and you notify the EB Division of such ineligibility within 60 calendar days, a COBRA notice containing enrollment and premium information will be mailed to you and/or your dependent at your home address on file with Employee Records. By enrolling in COBRA coverage within the allowed time frame and paying the total monthly premium and administrative charge, coverage for medical, pharmacy, vision and behavioral health, dental, vision only, and/or health care FSA will continue retroactive to the date of ineligibility without a break in coverage through the period of COBRA eligibility. Refer to the "**Notifications**" section for additional information.

When and How Can Changes Be Made & When Are They Effective?

General

If you experience a qualified status change during the plan year, you may be eligible to add dependents to or drop dependents from your current benefit plans, but you cannot change your current benefit plans. The list of events that constitute a qualified status change is provided in the "What is a qualified status change" sub-section below.

Qualified status changes must be verified through supporting documentation and must be consistent with the event as defined under IRC § 125. Benefit election changes are consistent with status changes only if the election changes are necessary or appropriate because of the status change.

Requested benefit changes must be submitted on a "Group Insurance Qualified Status Change" form and provided to the EB Division within 30 calendar days of the change (except for number 6 and 7 below where the period is 60 days). Supporting documentation will be requested through Dependent Audit Services. Failure to respond to or provide sufficient documentation to Dependent Audit Services will result in retroactive termination of coverage.

What is a qualified status change?

Qualified status changes are occurrences that cause either a gain or loss of eligibility. Examples of qualified status changes, as permitted by IRC Section 125, are listed below:

1. Change in status:
   a. Events that change an employee's legal marital status, including the following: marriage, death of spouse, divorce, legal separation, or annulment;
   b. Events that change an employee's number of dependents, including the following: birth, death, adoption, and placement for adoption. In the case of the Dependent Care FSA, a change in the age of the qualifying individual (e.g. child turns 13).
   c. Any of the following events that change the employment status of the employee, the employee's spouse or the employee's dependent:
      - termination or commencement of employment;
      - strike or lockout;
      - commencement of or return from an unpaid leave of absence (LOA) including FMLA;
      - change in residence or work site where eligibility no longer exists for the plan originally selected or where the employee or dependent becomes eligible in the new residence or work site;
      - change in the number of regularly scheduled hours to become benefit eligible or ineligible;
      - change in job or employment status that renders the employee benefit eligible or ineligible, such as moving from temporary status (benefit ineligible) to a benefit-eligible status, or changing from a contract position with no benefits to a position with benefits.
2. Dependent satisfies or ceases to satisfy eligibility requirements such as attainment of age or change in student status;
3. Judgment, decree or order resulting from a divorce, legal separation, annulment or change in legal custody, including a qualified medical child support order requiring accident or health coverage for an employee's child;
4. Significant cost change of a benefit plan for an employee (mid-plan year change) or the spouse's

plan (mid-plan year or plan year change), or coverage under a benefit plan for an employee (mid-plan year change) or the spouse's plan (mid-plan year or plan year) is significantly curtailed or ceases.

5. Entitlement or loss of entitlement for Medicare or Medicaid (the Arizona Health Care Cost Containment System) more commonly referred to by its acronym **AHCCCS**, the Medicaid program in Arizona.
6. You or your dependent's Medicaid or State Children's Health Insurance Program (SCHIP) coverage is terminated as a result of loss of eligibility.
7. You or your dependent becomes eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP.

Effective Date of the Change

Below are the qualified status changes and when the change becomes effective. For STD and life insurance, review the last two paragraphs of this sub-section.

Adding dependents, electing benefits if previously waived, or waiving benefits - due to birth, adoption, and placement for adoption

Employees may add a new dependent, waive benefits if currently enrolled, or enroll if currently waiving benefits, when a qualified status change occurs due to birth, adoption or placement for adoption. The coverage effective date is the date of the event (date of birth, date of adoption, or date of placement for adoption). Premium changes associated with the qualified status change become effective the pay period in which the new coverage is effective.

In accordance with ARS 20-1057 B, if your medical coverage is under a CIGNA CMG or OAP plan, coverage of a newborn child, a child placed for adoption or an adopted child will be effective from the date of birth or placement and will continue for the following 30 calendar days. There is no premium associated with coverage for the first 30 days as long as you do not enroll the child for ongoing coverage. In order for medical coverage to continue past the initial 30 days, you are required to enroll the child by completing the "Group Insurance Qualified Status Change" form timely and paying a premium retroactively to the date of the event if you are not currently in the appropriate coverage premium level (i.e., if you are paying the employee-only or employee-and-spouse premium instead of the employee and family or employee and child premium).

Adding or dropping dependents, electing benefits if previously waived, or waiving benefits - due to all other status change events (marriage, dependent attains or loses eligibility, court orders, legal guardianship, etc.)

Employees may add newly acquired or newly eligible dependents or drop covered dependents, waive benefits if currently enrolled, or enroll if currently waiving benefits, when a status change occurs other than birth, adoption or placement for adoption. When adding or dropping a dependent, the coverage effective date or the coverage termination date is prospective and is either the date the request is processed by the EB Division or no later than the first calendar day of the month following the date the "Group Insurance Qualified Status Change" form is received. Premium changes associated with the qualified status change become effective the pay period in which the new coverage or termination is effective.

Losing Eligibility – all status change events

When a dependent ceases to meet the definition of an eligible dependent, that dependent must be terminated from coverage. The dependent's coverage ends the last day of the pay period during which he/she lost eligibility. However, in the case of death, coverage ends the day following the date of death.

Short Term Disability (STD)

If you elect STD when you first become benefit eligible or during Open Enrollment, you may not change your election until the next Open Enrollment even if you have a qualified status change. The only exceptions that may apply are if you are subject to a Reduction in Force (see HR2403) or called to active military duty. In these cases, you ineligible to receive STD payments and are therefore required to drop coverage.

Life insurance

If you elected Additional Life insurance and/or Dependents Life insurance, you have special rules that apply. These plans are not subject to IRC Section 125. Please see the special rules that apply to these life insurance plans, in the "**Life Insurance Plan**" section.

What Changes Can I Make During The Plan Year?

Generally, your pre-tax benefit elections made either when newly eligible or during Open Enrollment are irrevocable during the plan year. However, when you have a qualified status change, you can add dependents to or drop dependents from your plans provided that the action is consistent with the status change. At any time during the plan year, changes can be made to After-Tax benefits, except for Short-Term Disability.

Provided below is a list of changes that you can make either to your coverage or benefit record. Some changes can be initiated by the employee through the Benefit Enrollment System [Employee Self Service (eSS)], others are system-generated events based on changes to your Job Record, and others are events controlled by the Employee Benefit Division in their role as Administrator.

Birth, Adoption, Placement for Adoption or Legal Guardianship Event (eSS)

- Add or drop coverage for your spouse, child, step-child or legal guardian
- If employee does not have coverage, elect coverage for the medical package[1], dental, life[2], FSA, and Group Legal
- If employee has coverage, waive coverage for the medical package[1], dental, life[2], FSA, and Group Legal; change the plan option for vision; or increase or decrease coverage for life[2] and FSA

Marriage Event (eSS)

- Add or drop coverage for your spouse, child, step-child or legal guardian
- If employee does not have coverage, elect coverage for the medical package[1], dental, life[2], FSA, and Group Legal
- If employee has coverage, waive coverage for the medical package[1], dental, life[2], FSA, and Group Legal; change the plan option for vision; or increase or decrease coverage for life[2] and FSA

Divorce/Annulment or Legal Separation Event (eSS)

- Add coverage for your child
- Drop coverage for your spouse, child, step child and legal guardian
- If employee does not have coverage, elect coverage for the medical package[1], dental, life[2] (but not spouse life), FSA, and Group Legal
- If employee has coverage, waive coverage for the medical package[1], dental, life[2], FSA, and Group Legal; change the plan option for vision; or increase or decrease coverage for life[2] (but not spouse life) and FSA

Dependent Gains Other Coverage Event (eSS)

- Drop coverage for your spouse, child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for life[2] and Group Legal
- If the employee does have coverage, waive coverage for the medical package[1], dental, life[2], FSA, and Group Legal; change the plan option for vision; or increase or decrease coverage for life[2] and FSA

Dependent Loses Other Coverage Event (eSS)

- Add coverage for your spouse, child, step-child or legal guardian

- If the employee does not have coverage, elect coverage for the medical package[1], dental, life[2], FSA, and Group Legal
- If the employee does have coverage, change plan option for vision; waive coverage for life[2], FSA and Group Legal; or increase of decrease coverage for life[2], and FSA

Dependent Becomes Eligible (eSS)

- Add coverage for your child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for Child Life[2], FSA and Group Legal
- If the employee does have coverage, waive coverage for FSA and Group Legal; increase coverage for Child Life[2]; increase or decrease coverage for FSA

Dependent No Longer Eligible (eSS)

- Drop coverage for your child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for Group Legal
- If the employee does have coverage, waive coverage for Child Life[2], FSA and Group Legal; or decrease coverage for FSA

Update Dependent Information Event (eSS)

- Update demographic information (name, gender, SSN, date of birth, relationship type, student flag or disabled flag for all dependents; address for beneficiaries) for your spouse, child, step-child, legal guardian, and beneficiary
- Add or delete beneficiaries

Change After Tax Benefits Event (eSS)

- If the employee does not have coverage, elect coverage for life[2]
- If the employee does have coverage, waive, increase or decrease coverage for life[2]

Change in Dependent Care Cost Event (eSS)

- If the employee has coverage, waive, increase or decrease coverage for Dependent Care FSA

Beneficiary Information Update Event (eSS)

- Add or delete beneficiaries
- Update demographic information (name, gender, SSN, date of birth, relationship type, and address) for existing beneficiaries

Change HSA Contribution or Catch-up Contribution Event (eSS)

- Elect, waive, increase or decrease the contribution to the Health Savings Account

Retiree to Active Event (System Generated)

- Add or drop coverage for your spouse, child, step-child or legal guardian
- If employee does not have coverage, elect coverage for the medical package[1], dental, life[2], STD, FSA, and Group Legal
- If employee has coverage, waive coverage for the medical package[1], dental, life[2], STD, FSA, and Group Legal; change the plan the medical package[1] and dental coverage; or increase or decrease coverage for life[2] , STD, and FSA

Newly Eligible Event (System Generated)

- Add or drop coverage for your spouse, child, step-child or legal guardian
- Elect coverage for the medical package[1], dental, life[2], STD, FSA, and Group Legal

Data Related Eligibility Change Event (System Generated)

The processing rules are variable, depending on the type of eligibility change, such as loss of eligibility for current option or gain of eligibility for current option. The Benefit Enrollment System determines which benefit(s) can be changed for this event and sends eSS the data needed to open certain benefit areas for enrollment.

Change in EOI Status Event (Administrator)

If the employee does not have coverage, elect coverage for life[2]

If the employee does have coverage, waive, increase or decrease coverage for life[2]

Add or Remove Court Ordered Dependent Event (Administrator)

- Add or drop coverage for your court-ordered dependent
- If the employee does not have coverage, elect coverage for the medical package[1], dental, life[2], FSA and Group Legal
- If the employee does have coverage, change the plan option for the medical package[1] and dental coverage; waive coverage for Group Legal, and waive, increase or decrease coverage for life[2], and FSA

Death of Spouse Event (Administrator)

- Add coverage for your child
- Drop coverage for your spouse, child, step-child or legal guardian
- If the employee does not have coverage, elect coverage for the medical package[1], dental, life[2] (except Spouse Life), FSA and Group Legal
- If the employee does have coverage, waive coverage for the medical package[1], dental, life[2], FSA and Group Legal; change plan options for vision coverage; increase or decrease coverage for life[2] (except Spouse Life), and FSA

Death of Child Event (Administrator)

- Drop coverage for your child, step-child or legal guardian
- If employee does not have coverage, elect coverage for Group Legal
- If employee does have coverage, waive coverage for Group Legal, or waive, or increase or decrease coverage for life[2], and FSA

Footnotes:

[1]The Medical package means medical, pharmacy, vision and behavioral health coverage

[2]Changes and/or increases to life insurance is subject to Evidence of Insurability rules

What Documentation is Required for Qualified Status Changes?

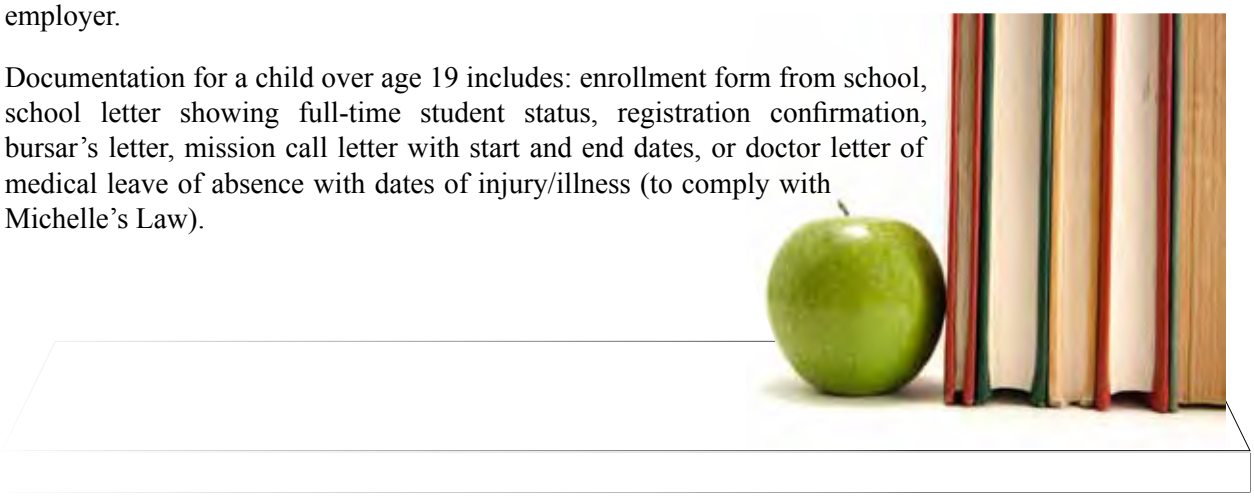
Documentation of your qualified status change is required and will be requested by letter from Dependent Audit Services. Refer to "**When and How Can Changes Be Made and When Are They Effective?**" section, "**General**" sub-section.

Documentation for adding a spouse includes: a redacted joint tax return or a marriage certificate and one of the following: joint bank or credit account, joint deed, mortgage or lease agreement, joint obligors on a loan, joint ownership or lease of a motor vehicle, or joint utility bill of mutual residence. Multiple proofs are required for spouses to verify that the employee and spouse are married and currently living together.

Documentation for adding a child includes: birth or adoption certificate, qualified medical child support order, official court documentation, or current tax return.

Documentation for dropping a spouse or child depends on the reason for the status change and includes: divorce decree or court order, death certificate, or document from the dependent's employer.

Documentation for a child over age 19 includes: enrollment form from school, school letter showing full-time student status, registration confirmation, bursar's letter, mission call letter with start and end dates, or doctor letter of medical leave of absence with dates of injury/illness (to comply with Michelle's Law).



Privacy

HIPAA Privacy Notice

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator and/or sponsor of the Program, or in its role as the health plan, makes available a notice through the EBC/Intranet **http://ebc.maricopa.gov/ehi** EB Home page setting forth its privacy practices. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to PHI. The privacy notice may be updated occasionally and such updates are communicated through **e*Nouncements**, accessible through the EBC.

Sharing Your Protected Health Information

You and your dependents' PHI will be shared with specific benefit plan representatives and others for the purposes of your health care treatment, payment for that treatment and health care operations (as defined in the HIPAA of 1996, as amended) of Maricopa County and of the benefit plan vendors, as well as for other purposes allowed or required by law. When you submit your enrollment application, are automatically enrolled in a benefit plan because you did not submit your enrollment application or decline enrollment timely, make an open enrollment election (including passive elections), submit a qualified status change or continue with your current coverage, you are acknowledging and accepting that Maricopa County and your health care providers, which could include CIGNA, CIGNA Dental, Walgreens Health Initiatives (WHI), Magellan Health Services, Delta Dental, EDS, The Standard, Sedgwick CMS, EyeMed Vision Care, and Automatic Data Processing (ADP), may share medical and administrative information concerning you and your dependents. By participating in the health plans, you are releasing Maricopa County and Maricopa County's plan administrators, benefit managers and vendors from any liability for any good faith release of PHI pursuant to this acknowledgement.

Employee Certification

By submitting your benefit elections, participating in open enrollment (including passive enrollments), or by allowing automatic enrollment in benefits, you are authorizing Maricopa County to take deductions from your paycheck and from any short-term disability payments you may receive, to pay for your benefit premiums and/or other costs or expenses.

Further, you are authorizing Maricopa County to take additional deductions from your paycheck and/or any short-term disability payment you may receive, to reimburse Maricopa County for any benefits you and/or your dependents were unauthorized or ineligible to receive because you provided inaccurate, incorrect and/or incomplete information to Maricopa County. Deductions to reimburse Maricopa County will be in accordance with the law. You are also authorizing the EB Division to send necessary personal information to your selected vendors to initiate and support your coverage.

Notice Regarding Use of Your Social Security Number or Health Insurance Claim Number

Disclosure of your Social Security Number (SSN) or your Health Insurance Claim Number (HICN) if enrolled in Medicare, for purposes of enrollment and other benefit-related issues is voluntary except when required under Section 111 of Public Law 108-173 (Medicare Secondary Payer Mandatory Insurer Reporting Requirements Act).

Identification (ID) cards from all vendors will carry either no ID number, an edited ID number (revealing only the last four digits of your SSN), your employee ID number, or a random system-generated number.

Your SSN is transmitted to the benefit plan vendors for administrative purposes. Some vendors will use your SSN as your ID number or cross-reference their assigned ID number to your SSN.

If you do not want your SSN transmitted to the benefit plan vendors and you are not required under the aforementioned Public Law to provide your SSN, you may request an Alternative ID number.

If you are participating in the flexible spending account plan, group legal plan, or the Choice Fund high-deductible medical plan, the vendor requires your SSN. If you do not want your SSN sent to the flexible spending account, group legal plan or in the case of Choice Fund, all health plan vendors, you should not enroll in these benefits.

Alternative ID Number

You may request an Alternative ID number to be used in lieu of using your SSN, except as specified above, by completing the Alternative ID Request form available on the EB Home page, or by sending your request in writing to the EB Division. You will be provided with a form to complete before the Alternative ID number can be assigned.

If you are completing your initial benefits enrollment and you do not want your SSN sent to the vendors, you should not complete your enrollment online. Notify the EB Division before the end of your enrollment period for assistance. Your enrollment (but not your benefit coverage effective date) in benefits will be delayed until the Alternative ID number is assigned.

Once assigned, the EB Division will provide you with your Alternative ID number and notify your medical, pharmacy, vision, behavioral health and dental vendors. Once the vendor links your enrollment to an Alternative ID number, you and your dependents will not be identifiable by your SSN. You are responsible for advising each provider that you have an Alternative ID number and that they must use that number instead of your SSN when filing claims or requesting eligibility information or authorizations for services.

You should be aware of the following possible consequences of having an Alternate ID number assigned:

- If the vendor uses a system-generated ID number, your Alternative ID number will be cross-referenced to the system-generated ID number. When you access services, your provider will verify your current eligibility by calling the vendor. The provider must use either your current Alternative ID number or your system-generated ID number so that your eligibility can be established, you can access services and your claims can be processed and paid.
- Additionally, when an Alternative ID number is assigned, if you have ever been identified by your SSN, some vendors do not have the technology to cross-reference your records to re-establish prior authorizations or referrals for your care or to process claims submitted under your SSN because the key link between you and their records (your SSN) has been broken. This may cause a temporary delay in receipt of services or result in denied claims until you notify the vendor to correct the records.

Wellness Initiatives and Incentives

Maricopa County values the health and well being of our employees. That's why we continue to improve our employee worksite wellness program by offering the following health and wellness initiatives and incentives that have been developed for our population based on biometric screening and health assessment results, as well as utilization trends.

We encourage you to participate in the initiatives and incentives for which you qualify in order to learn how you can take more control of your health and well being. If you would like additional information regarding the information below, call the EB Division or go the EB Home page and click on the Wellness tab. Wellness initiatives are communicated by **e*Nouncements** and Weekly Wellness Activities via the EBC. Please check with your department for its policy on attending wellness initiatives and programs during your scheduled work hours.

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Dental ~				
Brush Biopsy	Early detection of oral cancer through a brush biopsy.	Employees and/or dependents enrolled in CIGNA Dental	Information available at **http://www.maricopa.gov/benefits/ pdf/2010/CIGNA_Dental/oralcancerexam.pdf**	In-network: 20% co-insurance after deductible is met. Out-of-network: 40% co-insurance after deductible is met.
Dental Cleanings	A third dental cleaning is available to employees and/or dependents as a way of supporting preventive care, improving health and lowering overall costs for members with the following medical conditions: diabetes, women in their third trimester of pregnancy, renal dialysis patients, suppressed immune system patients (due to chemotherapy, HIV positive, organ transplant, or stem cell/bone marrow transplant) or head and neck radiation patients.	Employees and/or dependents who are enrolled in Delta Dental.	Information available at **http://www.maricopa.gov/benefits/pdf/2010/Delta_Dental/third_cleaning.pdf**	Covered at 100% (deducted from the benefit maximum)
Dental Oral Health Integration Program - Oral Health Diabetes and Cardiovascular Programs	Research has linked periodontal (gum) disease to complications for heart disease, stroke and diabetes. This program provides employees and/or dependents with 100% reimbursement of their out-of-pocket payment to the dentist for: periodontal root scaling & planing and periodontal maintenance. Periodontal maintenance is increased to four times per year under the program.	Employees and/or dependents who are enrolled in a County-sponsored CIGNA Dental and Medical plan and who participate in the CIGNA WellAware Program for diabetes or heart disease.	Contact CIGNA Information available at **http://www.maricopa.gov/benefits/pdf/2010/CIGNA_Dental/oralhealth.pdf**	No Cost

Pleas

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Dental Oral Health Integration Program - Oral Health Maternity Program℠	Since women with periodontal gum disease may be at increased risk for pre-term babies and that treatment for gum disease may reduce the likelihood of premature birth of women at risk, this program enhances dental benefits for expectant mothers. Eligible members may receive 100% reimbursement of copay or co-insurance for select covered services performed during pregnancy such as oral evaluation, periodontal scaling and root planing, periodontal maintenance, treatment of inflamed gums around wisdom teeth, and the frequency limitations for cleanings is waived to include an additional cleaning.	Employees and/or dependents who are enrolled in a County-sponsored CIGNA Dental and a CIGNA Medical plan.	Contact CIGNA Information available at **http://www.maricopa.gov/benefits/pdf/2010/CIGNA_Dental/oralhealth.pdf**	No Cost
~ Diabetes ~				
Diabetes Education	Appointment with a diabetes educator for assessment; Basic diabetes education class series; Continuing diabetes education class; and Intensive insulin management class.	Employees and their dependents who are enrolled in a County-sponsored CIGNA Medical plan.	At several CIGNA Medical Group facilities. See flyer on the EB Home page, under the Wellness tab. For general information call 623-876-2355.	Fee based classes
Diabetes Management Program	Meet 9 conditions to participate; **Click here** to review the brochure.	Employees and their dependents diagnosed with diabetes who are enrolled in a County-sponsored WHI pharmacy plan	Information available at **http://www.maricopa.gov/benefits/diabetes.aspx**	No Cost; Receive free diabetic medications and supplies for one year; annual recertification required for continued participation.
Take Charge of Your Diabetes Walgreens Optimal Wellness Program	Educational program provided by a diabetic-certified pharmacist over a one-year period. The program is available through WHI and the Joslin Diabetes Center, the global leader in diabetes research, care and education, dedicated to improving health outcomes for people with diabetes. The role of the pharmacist is to review your medical history and medications to assess your diabetes control regimen and to recommend ways for you to better manage your condition.	Diabetic employees and/or dependents who are 18 years of age or older and enrolled in a County sponsored WHI pharmacy plan; Participants can enroll and re-enroll annually for the program.	Call 877-924-4584 to enroll, Monday-Friday, 9 AM to 10 PM EST and Saturday 8 AM to 5 PM EST. Contact your health care provider and obtain a copy of your most recent lab tests for A1C, total cholesterol, HDL, LDL, and triglycerides to bring to your first appointment.	No Cost; Upon program completion, participants will be eligible to be reimbursed for up to 9 diabetic-related office visit copays for one plan year.

Pleas□

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Disease Management ~				
Chronic Disease Self-Management Program	Educational program developed by Stanford University for employees with chronic conditions such as asthma, arthritis, diabetes, high blood pressure, low back pain or heart disease; 6-week course for 2 ½ hours per week.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll through Pathlore Course Code: PED136B	No Cost; Receive a workbook, Living a Healthy Life with Chronic Conditions and an audio relaxation tape, Time for Healing
Well Aware Disease Management Program	A Program that offers telephonic guidance and resources from a registered nurse for diseases and conditions such as asthma, diabetes, COPD, low back pain, weight complications, heart disease, fibromyalgia, acid-related disorders, atrial fibrillation, decubitus ulcer, hepatitis C, inflammatory bowel disease, irritable bowel syndrome, osteoarthritis, osteoporosis, and urinary incontinence.	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan with specific diseases or conditions	A Well Aware nurse will contact you directly or you may enroll by calling 866-797-5833	No Cost

Pleas

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Ergonomics ~				
Ergonomics Classes	Various classes taught by Ergonomic Specialists; Custom classes are available for locations with at least 10 participants.	All employees	Enroll via Pathlore on the EBC Internet. Class Search under "Ergonomic Classes"	No Cost
Ergonomics Evaluation	Evaluation at your individual workstation.	All employees	Go to EB Home page and download the ergonomic request service form. Have your supervisor sign the form and fax to 602-506-2354. Some departments have ergonomic facilitators who handle all ergo requests.	No Cost
Ergonomics consult for seating, lighting, furniture, and equipment	Onsite evaluation of facility.	All employees	Go to EB Home page and download the ergonomic request service form. Have your supervisor sign the form and fax to 602-506-2354. Some departments have ergonomic facilitators who handle all ergo requests.	No Cost

Pleas□

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Medical Services ~				
24-Hour Health Information Line	A telephonic health information library where you can listen to pre-recorded information on over a hundred health topics. Or, speak to a nurse for answers to your questions, suggestions for helpful home care, or assessment of symptoms and direction to the most appropriate care	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982 for nurse assistance. To access the list of health information topics, go to **www.mycigna.com**, click on the "My Health" tab at the top of the page, find the "Health Management Resources" heading, then click on the "Health Information Line" link for more information about calling for live support or options to listen to a podcast.	No Cost
Adult Immunizations	Flu/Pneumonia (by Walgreens)	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan.	All County-sponsored worksite flu/ pneumonia shot clinics will be provided by Walgreens. Appointments will be required via Walgreens online appointment scheduler. You must be 18 years of age or older. You will be required to show your CIGNA medical card. Employees and their dependents may receive flu/pneumonia shots at Walgreens pharmacies on a first come, first served basis. You will be required to show your CIGNA medical card.	No out of pocket cost to employees and their dependents with a County-sponsored CIGNA medical card.
	Flu (by CIGNA)	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Employees and their dependents may receive flu shots at CIGNA Medical Groups and CareToday locations during specified hours on a "walk-in" basis.	
	Tdap (Tetanus, Diphtheria and Pertussis) (by CIGNA)	Employees enrolled in a County-sponsored CIGNA medical plan.	Watch for e*Nouncements and Weekly Wellness Activities	

Pleas

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Convenience Care Clinics (Take Care and Care Today Only)	Walgreens Take Care and CIGNA Care Today clinics, staffed by nurse practitioners or physician assistants, are located throughout the valley and provide treatment for acute, non-urgent and non-work-related injuries such as minor cuts, allergies, ear infections, sinusitis, strep throat, conjunctivitis, urinary tract infections; immunizations such as flu (seasonal), Tdap (tetanus, diphtheria & pertussis), pneumonia, flu, shingles, meningitis, mumps, measles and rubella, chicken pox, hepatitis A and B, gardasil, are also provided.	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Use the onsite Take Care clinic located on the 2nd floor of the County Administration building or find a Take Care clinic at **www.takecarehealth.com**. CIGNA Care Today locations are available at **www.cigna.com/cmgaz/index.html** Convenience Care clinics are open 7 days a week including evenings and most holidays. Service is offered on a first come, first served basis.	Receive a $10 discount off your normal PCP copay. Choice Fund medical plan participants may be seen by the provider, but will not receive the discount. Choice Fund medical plan members will pay customary charges until the deductible is met, and 10% of the customary charge thereafter until the out of pocket maximum has been met.
Onsite Pharmacy	Full service Walgreens retail pharmacy.	Benefit-eligible employees and dependents are eligible to use the onsite pharmacy	Located on the 2nd floor of the County Administration building. Open Monday - Friday, 7 AM - 5 PM. 602-283-9925 602-283-9934 (Fax)	WHI Consumer Choice Plan: members receive a $25 deposit into their Level 1 pharmacy account when they get their first prescription filled. Available once per lifetime and can only be used at the onsite pharmacy for prescriptions. WHI Co-insurance Plan: members save an additional 10% on generic medication and 5% on preferred brand medication when filling a 90-day prescription. This savings is realized when compared to the cost at another retail pharmacy but will not be realized if the member is paying the minimum copayment. Members paying the maximum copay of $36 for generic or $120 for preferred brand will save with the lower maximum of $28 for generic or $70 for preferred brand.

Pleas□

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Miscellaneous ~				
Healthy Rewards	A discount program available through CIGNA that offers discounts on weight management and nutrition products and services; fitness equipment, clubs and programs; tobacco cessation program, alternative medicine services; mind/body programs; dental care; vitamins and health and wellness products.	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Information available via **www.cigna.com** Type in Healthy Rewards in the search box	Product and service costs and discounts are available on the CIGNA Web site
~ Physical Activities ~				
Fitness Center	Located in the basement of the County Administration building; locker rooms with showers, weights and cardio equipment	All employees	Complete enrollment form, located on the Fitness Center web page: **http://www.maricopa.gov/benefits/fitnesscenter.aspx**	No Cost
~ Pregnancy ~				
Dental Cleanings	A third dental cleaning is available to employees and/or dependents as a way of supporting preventive care, improving health and lowering overall costs for members with the following medical conditions: diabetes, women in their third trimester of pregnancy, renal dialysis patients, suppressed immune system patients (due to chemotheraphy, HIV positive, organ transplant, or stem cell/bone marrow transplant) or head and neck radiation patients.	Employees and/or dependents who are enrolled in Delta Dental.	Information available at **http://www.maricopa.gov/benefits/pdf/2010/Delta_Dental/third_cleaning.pdf**	Covered at 100% (deducted from the benefit maximum)

Pleas

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Dental Oral Health Integration Program - Oral Health Maternity Program℠	Since women with periodontal gum disease may be at increased risk for pre-term babies and that treatment for gum disease may reduce the likelihood of premature birth of women at risk, this program enhances dental benefits for expectant mothers. Eligible members may receive 100% reimbursement of copay or co-insurance for select covered services performed during pregnancy such as oral evaluation, periodontal scaling and root planing, periodontal maintenance, treatment of inflamed gums around wisdom teeth, and the frequency limitations for cleanings is waived to include an additional cleaning.	Employees and/or dependents who are enrolled in a County-sponsored CIGNA Dental and a CIGNA Medical plan.	Contact CIGNA Information available at **http://www.maricopa.gov/benefits/pdf/2010/CIGNA_Dental/oralhealth.pdf**	No Cost
Healthy Pregnancies, Healthy Babies Program	Comprehensive maternity support program that provides education, assessment and a care plan.	Pregnant female employees or covered dependents enrolled in a County-sponsored CIGNA medical plan	Enroll by calling 800-244-6224 and ask to enroll in the Healthy Pregnancies, Healthy Babies Program	No Cost; $150 incentive available at program completion if enrolled in first trimester or $75 if enrolled in second trimester
~ Stress Management ~				
Work Life Balance	Classes offered through various mediums by Magellan Health Services.	All employees (for onsite classes); and employees enrolled in a County-sponsored CIGNA medial plan except Choice Fund (for online classes or webinars)	Enroll via Pathlore on the EBC Internet. Class Search under “Employee Benefits”	No Cost
~ Tobacco Use ~				
Non-Smoker Reward for Additional Life Insurance	Non-smoking employees who have been smoke-free for at least 12 months receive a rate reduction on additional life insurance.	All benefit-eligible employees	If you have either never smoked or have not smoked for more than 12 consecutive months, you should review your coverage level options in the Benefit Enrollment System under the Additional Life page. The coverage level options listed below identify if you are eligible to receive the incentive for additional life insurance. Non-Tobacco User (eligible) Tobacco User (not eligible)	Rate reduction for non-smokers when additional life insurance is purchased. Refer to life insurance rates in the “**Life Insurance Plan**” section.

Pleas

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Quit Tobacco Program	Six-week program in a group class setting at the worksite	Employees enrolled in a WHI pharmacy plan or Choice Fund medical plan are eligible to attend the classes. Employees enrolled in a WHI pharmacy plan are eligible for the incentive. Employees enrolled in the Choice Fund medical plan are not eligible to receive the incentive.	Call 602-372-7272 to enroll or email **lydiageorge@mail.maricopa.gov**	No Cost; OTC and prescription smoking cessation medications are covered 100% up to $500/plan year. Products are limited to a 30-day supply of smoking cessation product based on continued class attendance.
Non-Tobacco User Incentive	Non-tobacco using employees and their covered dependents who have been tobacco free for at least 6 months receive a reduction in the cost of their medical plan premium.	Employees enrolled in a County-sponsored CIGNA medical plan	Respond to the Non-Tobacco User Incentive options in the Benefit Enrollment System at time of enrollment. The options are listed below: I am a user of Tobacco products (default value in the system) I am not a Tobacco products user but a covered dependent is No one (employee & covered dependents(s)) uses Tobacco products The incentive is available only when the employee and all covered dependents do not and have not used tobacco products for at least 6 consecutive months. "Tobacco user" means the occasional or regular use of a tobacco product including, but not limited to, cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco. **Employees who do not provide accurate information and receive the incentive for which they are not eligible may be subject to disciplinary action up to and including termination**.	Save up to $480 per year ($20 per pay period) on your County-sponsored medical insurance premium. If you or a covered dependent were a user of tobacco and quit, you will be eligible for this incentive when you and all covered dependents in your household have been tobacco free for 6 consecutive months. Complete the Tobacco User Status form available on the Benefits Home page under General forms. Incentives are available on a prospective basis from the date the form is received in the EB Division.
Smoke Free	One-on-one monthly telephonic health coaching sessions for six months with one follow-up call nine months after enrollment. Enrollees receive step-by-step quitting advice, health education and motivational materials including a workbook to help track their smoke-free progress.	Employees and their dependents age 18 and above enrolled in a WHI pharmacy plan	Call 866-661-6781 to enroll. Please mention you are registering for the WHI Smoke Free program offered by Maricopa County.	No Cost; OTC and prescription smoking cessation medications are covered 100% up to $500/plan year. Products are limited to a 30-day supply of smoking cessation product per coaching call.

Pleas□

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Weight Management ~				
Am I Hungry?	An 8-week workshop that teaches you how to be in charge of your eating instead of feeling out of control; eat the foods you love without overeating and without guilt, and eat healthier foods without depriving or restricting yourself.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll via Pathlore Course Code: LIF160	No Cost
Nutritional Counseling	3 self-referral nutritional counseling visits with a registered dietician at designated CIGNA Medical Group facilities. Additionally, if enrolled in a CIGNA WellAware Disease management program, you can speak with a registered dietician 24/7 over the telephone.	Employees and their dependents who are enrolled in a County-sponsored CIGNA Medical plan.	Nutritional counseling is available at select CIGNA Medical Group facilities. Call 623-876-2555 for general information. If you are enrolled in the CIGNA WellAware program, call 800-249-6512 to speak with a registered dietician 24/7. If you are not enrolled in the WellAware program, call the number above to see if you qualify for enrollment.	For nutritional counseling visit, the PCP copay is charged per visit. No cost for telephonic WellAware consult.
Waisting Away Incentive Program	Program offering a reward for losing weight when attending Weight Watcher (WW) classes. (Does not apply to participants in the online WW Program.)	Employees and their dependents age 10 and up enrolled in a County-sponsored CIGNA medical plan	When you have completed program requirements go to: **http://www.maricopa.gov/benefits/ww.aspx** Must provide a copy of your paid receipt for the WW 10-week program along with a copy of the WW booklet showing attendance dates, and your beginning and ending weight	Attend 8 of 10 WW classes in a 10-week period and lose 10 pounds to receive $120 reimbursement via paycheck. $120 incentive effective for Weight Watchers 10-week sessions beginning after July 1, 2010. **Note**: Reimbursement is considered taxable income.
Weight-to-Go	8-week, 1½ hour class taught by a Registered Dietician. Includes 6-month follow-up class.	Employees enrolled in a County-sponsored CIGNA medical plan	Enroll via Pathlore. Watch for **e*Nouncements**	No Cost
Weight Watchers at Work	10-week program that focuses on portion control, mindful eating and lifestyle changes.	All employees	Enroll through Weight Watchers 602-248-0303	$120 per each 10-week session. Costs may increase without notice.

Pleas

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
~ Health Screenings ~				
Biometric Screening	Voluntary, brief confidential personal health history, measurements of height, weight, waist circumference, body fat composition, non-fasting or fasting cholesterol and glucose levels (finger stick), and blood pressure. Based on the results of your Biometric Screening, a health coach, provided by Magellan Health Services, may call you to work with you one-on-one to help you identify and achieve your health and wellness goals. See "Health Coaching" initiative on this table. You'll receive a personalized results booklet at the end of your screening that a wellness coach will review with you. Take it to your next doctor's visit, or use it to ask your doctor questions to learn more about your health and to make simple changes to improve your health status.	Employees enrolled in a County-sponsored CIGNA medical plan	Screenings are performed by appointment only at several Maricopa County worksite locations and at selected CIGNA Medical Group facilities during the mass biometric screening event (generally March - May). During this time, go online to www.cignascreenings.com/maricopa or call 800-694-4982 Monday - Friday 8 AM - 6 PM MST to schedule your appointment. e*Nouncements provide scheduling details during the mass event around the Open Enrollment period. Additional information is available on the EB Home page or under the "Wellness" tab. Screenings are available for new hires or others missing the mass event on a first come, first served basis at CareToday clinics throughout the year.	No Cost; You can save $5 per pay period up to a total of $120 annually per plan year. If you are newly eligible to receive the incentive, you must complete your screening within 45 calendar days of your medical benefit effective date for the incentive to be retroactive to such date. Otherwise, the incentive will be available on a prospective basis, the next pay period after completion. Screenings must be completed each year in order to continue receiving the incentive for the next plan year. Screenings completed Jan. 1 or thereafter qualify for the incentive for the next plan year.
Blueprint for Wellness	30+ fasting lab tests and a confidential personal lab report.	Employees enrolled in a County-sponsored medical plan who have not participated in a Blueprint event in the last 12 months	By appointment only; scheduled online through Blueprint for Wellness	No Cost

Pleas□

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Health Assessment	Voluntary online questionnaire from the University of Michigan regarding your health and lifestyle. Confidential results are calculated and provide you with an assessment of your health status. The questionnaire asks information regarding biometric measures such as weight, blood pressure and cholesterol levels so it is advisable to take the assessment soon after participating in the Biometric Screening initiative. Based on your responses, you will also receive an invitation to participate in an online coaching program. Print a summary of your health report to take to your next doctor's visit, or use it to ask your doctor questions to learn more about your health and to make simple changes to improve your health status.	Employees enrolled in a County-sponsored CIGNA medical plan	Available online at **www.mycigna.com**; registration instructions and directions on how to access the health assessment tool are available on EB Home page or under the "Wellness" tab.	No Cost; You can save $5 per pay period up to a total of $120 annually per plan year. If you are newly eligible to receive the incentive, you must complete your assessment within 45 calendar days of your medical benefit effective date for the incentive to be retroactive to such date. Otherwise, the incentive will be available on a prospective basis, the next pay period after completion. Assessments must be completed each year (starting in January and ending by the end date of Open Enrollment) in order to continue the incentive for the next plan year.
Health Coaching	Voluntary coaching program for employees with certain risks identified through the Biometric Screening Program and/or Health Assessment; help with developing a personal action plan, overcoming personal challenges, and staying motivated with one-on-one support and encouragement.	Employees who participated in the Biometric Screening Program and/or Health Assessment who have certain risk factors	Health Coach will contact you directly by phone	No Cost
Mobile Onsite Mammography (MOM)	Mammography screening.	Annually for female employees at least 40 years of age enrolled in a County-sponsored CIGNA medical plan; other insurance also accepted	By appointment through MOM 480-967-3767 **www.mobileonsitemammography.com** Watch for **e*Nouncements** to sign up	No Cost

Pleas□

Initiative	Description	Who is Eligible?	How to Access Services/Incentives	Cost/Incentive
Onsite Screenings	Blood pressure checks; Body composition evaluations; Strength test (dynamometer); Flexibility test (sit & reach); Sub-Max cardio test (3 minute step); Bone density; Sun damage awareness (Dermascan); Diabetic foot screening; and Spirometry.	Employees and their dependents enrolled in a County-sponsored CIGNA medical plan	Watch for **e*Nouncements** to sign up	No Cost
Prostate Onsite Project (POP)	Prostate Antigen Specific (PSA) blood test and digital rectal exam.	Annually for male employees at least 40 years of age enrolled in a County-sponsored CIGNA medical plan	By appointment through POP 480-964-3013 **www.prostatecheckup.com** Watch for **e*Nouncements** to sign up	No Cost
Ultrasound Screening	Ultrasound screenings for osteoporosis/bone density, carotid artery, abdominal aortic aneurysm (AAA), peripheral arterial disease (PAD), thyroid, gall bladder, kidneys and liver.	All employees	By appointment through Health First by calling 800-209-4848	Any 3 tests - $115 Any 5 tests - $140 Any 8 tests - $160 Prices are subject to change without notice.

Please note, that wellness programs may be discontinued during the benefit plan year based on availability or funding for the program.

Choosing The Plan That Suits You

Maricopa County is committed to promoting better health for its employees and their families by continually evaluating our Program. Furthermore, Maricopa County continually looks for innovative solutions that will help effectively control short- and long-term health care costs without sacrificing the quality of health care. We believe that by providing a wide selection of medical insurance benefit options, every employee has the opportunity to choose the "right plan" to meet their individual needs.

To help you decide what medical plan is "right for you", consider the following questions in the tables below. Table A is specific to the high deductible medical plan, and Table B applies to all other medical plans. Please take the time to review both tables and determine the plans that interest you.

TABLE A

Is the Choice Fund Medical Plan with Health Savings Account Right for You?	Yes/No
Are you interested in enrolling in a free medical plan ($0 payroll deduction for employee or family coverage)?* *For non-tobacco users participating in Biometric Screening and Health Assessment	
Would you like to get free preventive medical care and preventive medication (generic and preferred-brand are Free but non-preferred brand is not) without having to meet any deductible?	
Are you interested in getting an annual tax-free contribution* by the County to your own Health Savings Account? *Receive up to a $500 individual or $1,000 family contribution annually. Amount is prorated by number of months enrolled.	
Do you take an active role in managing your health care and health care costs?	
Is it important to have the freedom to go to any doctor you choose and access to providers without referrals?	
Do you want to have a fully portable savings account that rolls over the unused account balance year-to-year and that you can take with you if you leave your employment?	
Do you enjoy managing and investing your money in programs like Deferred Compensation or other investment plans and watching the balance grow over the years?	
Are you interested in being able to save for future medical and retiree health expenses on a tax-free basis?	

If you answered Yes more than twice, please turn to the Medical Plan Summary Chart for more information on the CIGNA Choice Fund medical plan.

TABLE B

If the Choice Fund Medical Plan is not right for you, determine what other plan is BEST FOR YOU!

Question / Answer	Yes/No	Applicable Plans
Q: Will you and/or your covered dependents live outside of Maricopa County during the plan year? **A**: The OAP High and Low plans offer out-of-network benefits and national networks of providers.		OAP High OAP Low
Q: Do you like to use the CIGNA Medical Group Centers exclusively for your primary care needs? **A**: If you enjoy the convenience of receiving your primary medical care through a CIGNA Medical Group Centers (owned and operated by CIGNA), you may want to consider the CMG High or CMG Low benefit plans.		CMG High CMG Low
Q: Do you prefer lower out-of-pocket costs (copays and co-insurance) when deciding which medical benefit plan to choose? **A**: Lower out-of-pocket costs, such as copays, mean that your per paycheck deduction will be higher. CMG High and OAP In-network benefit plans offer the lowest copays.		CMG High OAPIN
Q: Are your doctors and hospitals covered under the medical benefit plans you choose? **A**: For all benefit plans, CIGNA contracts with a variety of medical providers for different services that includes doctors, hospitals, laboratories, etc. Some benefit plans offer larger networks that include private practice primary care physicians and national networks to cover out-of-area services. The OAP In-network, OAP Low, and the OAP High plans offer large provider networks.		OAPIN OAP Low OAP High
Q: Do you like having the flexibility of seeing providers who are outside of the plan's network? **A**: The OAP Low and OAP High plans offer coverage of providers who are not in the plan's network.		OAP Low OAP High
Q: Is having direct access to network providers without a referral important to you? **A**: For the OAP In-Network, OAP Low and OAP High plans, no referrals to network specialists is necessary.		OAPIN OAP Low OAP High

Find out how the plans work and compare plans to determine which plan works best for you.
Log on to **www.mycignaplans.com** using **Username**: Maricopa2010 and **Password**: cigna

QUESTIONS?

Refer to the "Who to Contact" section at the end of this booklet.

Medical Plans

Administered by CIGNA

This section provides a brief summary of information on the different medical plans offered, how they operate and the cost of services and premiums. For more detailed information, please contact the CIGNA Pre-Enrollment or customer service phone number listed in the "**Who to Contact**" section. Choices include CIGNA Medical Group (CMG), a managed-care health maintenance organization (HMO) plan with a limited CIGNA provider network, Open Access Plus In-Network (OAPIN), an HMO plan with open access to specialists within the CIGNA provider network, Open Access Plus (OAP), an HMO plan with open access to specialists both within the CIGNA provider network and outside of the network, and CIGNA Choice Fund, a high deductible health plan, that comes with a Health Savings Account. Some plans have a high and a low option from which to choose. High options have higher premiums but lower copayments and co-insurance for services while low options have lower premiums but higher copayments and co-insurance.

Incentives

If you enroll in a medical plan, you must review the Non-Tobacco User Incentive option in the Benefit Enrollment System and answer the question regarding the tobacco use status for yourself and any of your dependents that you enroll in your plan. When no one uses tobacco products, you receive an incentive of up to $480 per plan year that helps reduce the cost of your medical insurance premium. The questions are listed below:

- I am a user of Tobacco products;
- I am not a Tobacco products user but a covered dependent is;
- No one (employee & covered dependents) uses Tobacco products.

If you do not respond to this option, it will default to "I am a user of Tobacco products" and you will not receive the incentive.

"Tobacco User" means the occasional or regular use of a tobacco product including but not limited to cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco within the last six consecutive months. Refer to the "Wellness Initiatives and Incentives" table under "**Non-Tobacco User Incentive**" for details.

Enrollment in a medical plan requires you to respond to options in the Benefit Enrollment System regarding your Biometric Screening and Health Assessment participation. These initiatives apply only to you, the employee, and not to your covered dependents. When you participate in either or both initiatives, you receive an incentive of up to $120 per plan year per initiative that helps reduce the cost of your medical insurance premium. If you do not respond to these options, they will default to a non-participation status and you will not receive the incentive. Refer to the "Wellness Initiatives and Incentives" table under "**Biometric Screening**" and "**Health Assessment**" for details.

Employees who do not provide accurate information and therefore receive incentives for which they are not eligible may be subject to disciplinary action up to and including termination. Additionally, providing inaccurate information regarding tobacco user status may result in the life insurance company rescinding your life insurance coverage.

Other Services

All medical plans include the following, except as noted

24-hour worldwide emergency care.

24-hour Health Information Line[sm]: Provides access to health information from Registered Nurses at any time. When you are not sure where to go to seek non-emergency care, you can call and speak with a nurse who can respond to your health care questions, direct you to the nearest participating medical facility or provide suggestions for helpful home care that may comfort you until you can see your doctor. Call 800-244-6224 and listen for the prompt for the 24-hour Health Information Line or call 800-564-8982. You also have access to the Health Information Library where you can listen to taped programs on hundreds of topics. Refer to the "**Wellness Initiatives and Incentives**" section for information on how to access the list of topics.

Alternative Medicine: Twenty self-referred in-network only alternative medicine visits per plan year are covered. Copayments or co-insurance vary depending on the medical plan selected. A $60 credit for herbal/homeopathic or natural supplies dispensed in conjunction with an office visit is also covered for all plans. Providers in CIGNA's designated alternative medicine network must be used when accessing this benefit. Not all services are available at all locations. Refer to the "Alternative Medicine Information" flyer available on the EB Home page under the CIGNA tab and then under the "Other Forms and Documents" heading.

Covered services are:

- Physician evaluation and management
- Physical medicine
- Acupuncture/acupressure
- Massage therapy
- Homeopathic consultation
- Biofeedback/guided imagery

Behavioral Health/Substance Abuse: Provided by Magellan Health Services (except for CIGNA Choice Fund medical plan where behavioral health/substance abuse benefits are provided by CIGNA Behavioral Health). Refer to the "**Behavioral Health and Substance Abuse**" section for benefit details.

Case Management: Case management involves you (or your dependents) with specific complex health care needs, such as oncology, burns, heart disease complications and high-risk pregnancies, for which a treatment plan is formulated and implemented by CIGNA to improve your health status. If you (or your dependents) choose to disenroll or not participate in Case Management, you will be charged an additional $250 for related services.

CIGNA Care Network Specialist Discount: When selecting in-network specialty care through a CIGNA Care Network (CCN) provider, the office visit is offered at a $15 lower copayment for all medical plans (except the Choice Fund medical plan). The CIGNA Care Network is a high-performing cost-effective specialty network that meets certain criteria related to quality and efficiency. Refer to the "**Glossary of Terms**" section to see which specialties participate in the CCN network. CCN providers are identified in the CIGNA online provider directory at **www.cigna.com** by a Tree of Life symbol.

Guesting Privileges: Provides access to in-network benefits while your dependents are temporarily absent from the service area. Call the CIGNA Customer Service Department to determine whether your dependent qualifies to participate. Certain restrictions apply.

Healthy Rewards Program: Discounts are provided on alternative health services and health and wellness products such as fitness club memberships, chiropractic services, therapeutic massage, acupuncture, cosmetic dentistry, laser vision correction, vitamins and herbal supplements, and hearing aids and tests. Call 800-870-3470 to find out more information or go online to **www.cigna.com/healthyrewards**.

myCIGNA.com: Access your benefit and claim information, request an ID card, view your provider directory, change your PCP, take your Health Assessment and more through this secure online Web site.

Pharmacy Benefit: Provided by Walgreens Health Initiatives (except for CIGNA Choice Fund medical plan where the pharmacy benefit is provided by CIGNA). You will select your pharmacy benefit separately from your medical plan. Refer to the "**Pharmacy Benefit**" section for plan choices and benefit details.

Urgent Care: Urgent care situations require prompt medical attention, but are not emergencies. If you go to urgent care seeking medical treatment and the urgent care provider directly refers you to the emergency room, your urgent care copay or co-insurance will be reimbursed once CIGNA processes the emergency room claim. It may take up to 30 business days to receive reimbursement from CIGNA for your urgent care copay. If you have questions regarding your reimbursement please call CIGNA customer service. Urgent care locations can be viewed at **http://www.maricopa.gov/benefits/pdf/2010/CIGNA/urgent_care_listing.pdf**.

Vision Benefit: Provided by EyeMed Vision Care. See the "**Vision Benefit Plan**" section for benefit details.

Wellness Programs: **Well Aware for Better Health** is an integrated disease management program helping CIGNA members manage asthma, low back pain, cardiovascular disease, diabetes, chronic obstructive pulmonary disease, weight complications, and targeted conditions such as fibromyalgia, hepatitis C, irritable bowel syndrome, acid-related disorders, atrial fibrillation (irregular or fast heartbeat), decubitus ulcer (pressure or bed sore), inflammatory bowel disease, osteoarthritis, osteoporosis and urinary incontinence. To see if you qualify, call 800-249-6512. Once you are enrolled in a disease management program, you can contact a nurse or dietician for consultation at 877-888-3091.

Healthy Pregnancies, Healthy Babies is another wellness program for prenatal guidance, available by calling 800-244-6224. An incentive is available when you complete this program. If you enroll during the first trimester you will receive $150, or $75 for second trimester enrollment.

Additional wellness programs are available to employees enrolled in County medical and/or pharmacy plans. Please refer to the "**Wellness Initiatives and Incentives**" section for further information.

CIGNA Administers the Medical Plan

If you have questions regarding covered benefits, claims payment, the appeal process or a provider's participation status, contact CIGNA Customer Service Department, 24 hours per day, 7 days per week. See the "**Who to Contact**" section for details. Additional resources include CIGNA's Web sites **www.cigna.com**, **www.mycigna.com**, and **www.mycignaplans.com**.

Medical claims are mailed to:

CIGNA
P.O. Box 182223
Chattanooga, TN 37422-7223

The information on the next several pages is brief summaries of each plan. The detailed Plan Descriptions are available on the EB Home page. Refer to the "**Who to Contact**" section.

Medical Copay / Co-insurance Comparison Chart

Benefit Provision		CMG High
		In-Network Coverage Only
Plan Deductible *(These work differently for CMG, OAP, and Choice Fund Plans. See "Plan Deductibles" sub-section for details)*	Single	$250 Facility Deductible
	Family	$500 Facility Deductible
Standard Percent of Co-insurance		N/A
Out-of-Pocket Maximum *(See the "Out-of-Pocket Maximums" sub-section for details)*	Single	$1,000
	Family	$2,000
Pre-existing Condition Limitation		None
Preventive Care		$0 (FREE)
Primary Care Physician Services[1]		$25
Convenience Care Clinic Visit *(only applies to Take Care and Care Today Clinics)*		$15
Specialty Care Physician Services - CCN/Non-CCN		$35* / $50**
Advanced Radiological Imaging: CAT, PET, MRI, MRA Scans and nuclear cardiac studies		$50/type of scan/day***
Allergy Injections - CCN/Non-CCN		$13* / $28**
Independent Lab and X-ray facility		$0
Inpatient Hospital Facility Services *(including delivery)*		$50/day, 5 day max., after deductible
Inpatient and Outpatient Professional Services *(Surgeon, Radiologist, Anesthesiologist, Pathologist)*		$0
Outpatient Hospital Facility Services		$100 after deductible
Pre- & Post-natal Exams *(after pregnancy has been determined)*		$35* / $50**, waived after 1st visit
Urgent Care *(Copay reimbursed if referred directly to Emergency Room)*		$75, waived if admitted to hospital
Emergency Room		$175, waived if admitted
Ambulance		$0
Durable Medical Equipment/Medical Supplies No annual limit *(copay applies to each item)*		$75 DME; $0 consumable supplies
External Prosthetics		$0
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr. except as noted		$50**/provider per day****
Cardiac Rehab; 36 visits/yr.		$50** per visit
Alternative Medicine; 20 visits/yr. maximum $60 credit for supplies/products		Same as PCP copay
Behavioral Health/Pharmacy		Magellan/WHI

For more detail, review the medical plan summaries on the EB Home page under the Open Enrollment tab, Medical section or the CIGNA tab or compare plans on www.mycignaplans.com (User ID: Maricopa2010 and Password: cigna)

*You pay lower copays when you use a specialist with the CIGNA Care Network (CCN) designation; for more information see the Glossary of Terms.

**You pay higher copays when you use a specialist without the CCN designation. Not all specialties are included in the CCN. When the specialty is not included in the CCN, the higher Non-CCN copay will apply.

***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the applicable place of service co-insurance & deductible.

****Chiropractic visits have a separate 60 visit limit per plan year. Other therapies have a combined 60 visit limit per plan year.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists; in this case the applicable CCN or Non-CCN specialist copay applies.

Medical Copay / Co-insurance Comparison Chart

CMG Low	OAPIN
In-Network Coverage Only	
$300 Facility Deductible	$250 Annual Deductible
$600 Facility Deductible	$500 Annual Deductible
10%	N/A
$5,000	$1,500
$10,000	$3,000
None	Yes, same as for OAP Low & Choice Fund plans
$0 (FREE)	
$35	$30
$25	$20
$55* / $70**	$40* / $55**
$100/type of scan/day***	
$18* / $33**	$15* / $30**
$0	$0 after deductible
$150/day, 5 day max., plus 10% after deductible	$75/day, 5 day max., after deductible
$0	$0 after deductible
$250 plus 10% after deductible	$100 after deductible
$55* / $70**, waived after 1st visit	$40* / $55**, waived after 1st visit after deductible
$75, waived if admitted to hospital	
$175, waived if admitted	
$0	$0 after deductible
$75 DME; $0 consumable supplies	$75 DME after deductible; $0 consumable supplies after deductible
$0	$0 after deductible
$70**/provider per day****	$55**/provider per day
$70** per visit	$55** per visit
Same as PCP copay	
Magellan/WHI	

For more detail, review the medical plan summaries on the EB Home page under the Open Enrollment tab, Medical section or the CIGNA tab or compare plans on **www.mycignaplans.com** (User ID: Maricopa2010 and Password: cigna)

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****Chiropractic visits have a separate 60 visit limit per plan year. Other therapies have a combined 60 visit limit per plan year.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists; in this case the applicable CCN or Non-CCN specialist copay applies.

Medical Copay / Co-insurance Comparison Chart

Benefit Provision		OAP High	
		In-Network	Out-of-Network
Plan Deductible *(These work differently for CMG, OAP, and Choice Fund Plans. See "Plan Deductibles" sub-section for details)*	Single	$350 Annual Deductible	$700 (one way accumulation)
	Family	$700 Annual Deductible	$1,400 (one way accumulation)
Standard Percent of Co-insurance		N/A	30% of max reimbursable charge
Out-of-Pocket Maximum *(See the "Out-of-Pocket Maximums" sub-section for details)*	Single	$2,000	$4,000
	Family	$4,000	$8,000
Pre-existing Condition Limitation		Yes, same as for OAP Low & Choice Fund plans	
Preventive Care		$0 (FREE)	Covered in-network only
Primary Care Physician Services[1]		$35	30% after deductible
Convenience Care Clinic Visit *(only applies to Take Care and Care Today Clinics)*		$25	30% after deductible
Specialty Care Physician Services - CCN/Non-CCN		$45* / $60**	30% after deductible
Advanced Radiological Imaging: CAT, PET, MRI, MRA Scans and nuclear cardiac studies		$100/type of scan/day***	30%***
Allergy Injections - CCN/Non-CCN		$18* / $33**	30% after deductible
Independent Lab and X-ray facility		$0 after deductible	30% after deductible
Inpatient Hospital Facility Services *(including delivery)*		$100/day, 5 day max., after deductible	30% after deductible
Inpatient and Outpatient Professional Services *(Surgeon, Radiologist, Anesthesiologist, Pathologist)*		$0 after deductible	30% after deductible
Outpatient Hospital Facility Services		$150 after deductible	30% after deductible
Pre- & Post-natal Exams *(after pregnancy has been determined)*		$45* / $60**, waived after 1st visit after deductible	30% after deductible
Urgent Care *(Copay reimbursed if referred directly to Emergency Room)*		$75, waived if admitted to hospital	$75, waived if admitted to hospital
Emergency Room		$175, waived if admitted	$175, waived if admitted
Ambulance		$0 after deductible	$0 after deductible
Durable Medical Equipment/Medical Supplies No annual limit *(copay applies to each item)*		$75 DME after deductible; $0 consumable supplies after deductible	30% after deductible
External Prosthetics		$0 after deductible	30% after deductible
Chiropractic Services, Pulmonary Rehab, Physical, Speech, Occupational and Cognitive Therapy 120 visits maximum combined/yr. except as noted		$60**/provider per day	30% after deductible/provider per day
Cardiac Rehab; 36 visits/yr.		$60** per visit	30% after deductible
Alternative Medicine; 20 visits/yr. maximum $60 credit for supplies/products		Same as PCP copay	Covered in-network only
Behavioral Health/Pharmacy		Magellan/WHI	

For more detail, review the medical plan summaries on the EB Home page under the Open Enrollment tab, Medical section or the CIGNA tab or compare plans on **www.mycignaplans.com** (User ID: Maricopa2010 and Password: cigna)

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***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the applicable place of service co-insurance & deductible.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists; in this case the applicable CCN or Non-CCN specialist copay applies.

[2]Lifetime maximum of $5 million applies.

Medical Copay / Co-insurance Comparison Chart

OAP Low		Choice Fund-HSA[2]:	
In-Network	Out-of-Network	In-Network	Out-of-Network
$500 Annual Deductible	$1,000 (one way accumulation)	$1,200 (cross accumulated) Annual Deductible; up to $500 contribution by Maricopa County to your HSA	
$1,000 Annual Deductible	$2,000 (one way accumulation)	$2,400 (cross accumulated) Annual Deductible; up to $1,000 contribution by Maricopa County to your HSA	
10%	30% of max. reimbursable charge	10%	30% of max. reimbursable charge
$5,000	$10,000	$2,000 (cross accumulated)	
$10,000	$20,000	$4,000 (cross accumulated)	
12 months if treatment was received in prior 90 days. Waived (on month-by-month basis) with Certificate of Creditable Coverage and for employees & dependents currently covered by a County medical plan for at least 12 months. Certificate of Creditable Coverage must be sent to CIGNA.			
$0 (FREE)	Covered in-network only	$0 (FREE) no deductible	Covered in-network only
$45	30% after deductible	10% after deductible	30% after deductible
$35	30% after deductible	10% after deductible	10% after deductible
$60* / $75**	30% after deductible	10% after deductible	30% after deductible
10%***	30%***	10% after deductible	30% after deductible
$23* / $38**	30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible; $0, no deductible if preventive	30% after deductible
$350/day, 5 day max., plus 10% after deductible	$700/day, 5 day max., plus 30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible	30% after deductible
$500 + 10% after deductible	$1,000 + 30% after deductible	10% after deductible	30% after deductible
$60* / $75** + 10% after deductible	30% after deductible	10% after deductible	30% after deductible
$75, waived if admitted to hospital	$75, waived if admitted to hospital	10% after deductible	10% after deductible
$175, waived if admitted	$175, waived if admitted	10% after deductible	10% after deductible
10% after deductible	10% after deductible	10% after deductible	10% after deductible
$75 + 10% DME after deductible; $0 consumable supplies after deductible	30% after deductible	10% after deductible	30% after deductible
10% after deductible	30% after deductible	10% after deductible	30% after deductible
$75**/provider per day	30% after deductible/provider per day	10% after deductible/provider per day	30% after deductible/provider per day
$75** per visit	30% after deductible	10% after deductible	30% after deductible
Same as PCP copay	Covered in-network only	10% after deductible	Covered in-network only
Magellan/WHI		CIGNA Behavioral Health/CIGNA Pharmacy	

For more detail, review the medical plan summaries on the EB Home page under the Open Enrollment tab, Medical section or the CIGNA tab or compare plans on **www.mycignaplans.com** (User ID: Maricopa2010 and Password: cigna)

*You pay lower copays when you use a specialist with the CIGNA Care Network (CCN) designation; for more information see the Glossary of Terms.

**You pay higher copays when you use a specialist without the CCN designation. Not all specialties are included in the CCN. When the specialty is not included in the CCN, the higher Non-CCN copay will apply.

***Does not apply to inpatient facility services; subject to applicable place of service co-insurance & plan deductible; Associated ancillary charges are subject to the applicable place of service co-insurance & deductible.

[1]A limited number of primary care physicians are contracted with CIGNA as specialists; in this case the applicable CCN or Non-CCN specialist copay applies.

[2]Lifetime maximum of $5 million applies.

Medical Plan Summary Chart

Benefit Provision:	CMG High:		CMG Low:		OAPIN:	
Type of Plan *(as licensed)*	HMO		HMO		HMO with Open Access Specialists (similar to a PPO)	
Service Area Where Care Must be Received	Maricopa County only, except for emergency care				Nationally	
Residency Requirement	Must work or reside in Maricopa County				None	
Primary Care Physician (PCP) Required?	Yes; may only use PCP's who practice in CIGNA Medical Group Centers				No	
Referral Required?	Yes, except to obstetrician/gynecologist, urgent care, emergency care, chiropractic care, & alternative medicine				No	
Out-of-Network Coverage	No					
Network	AZ-CIGNA Medical Group Network AZ812				National Open Access Plus AZ300	
Prior Authorization	Provider's responsibility					
Per Pay Period (24/yr.) Medical Premiums**	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$37.18	$132.56	$34.66	$94.10	$46.10	$145.61
Employee + Spouse	$56.39	$142.47	$48.05	$104.56	$104.57	$159.24
Employee + Child(ren)	$44.51	$139.20	$39.88	$102.07	$83.13	$155.50
Employee + Family	$75.58	$147.35	$60.74	$106.57	$140.62	$164.98

**The premium will be reduced by $20 per pay period if the entire household (employee and all covered dependents) is tobacco-free for the past six consecutive months; and/or by $5 per pay period for voluntarily participating in the biometric screening initiative; and/or by $5 per pay period for voluntarily participating in the health assessment initiative.

Find out how the plans work and compare plans to determine which plan works best for you. Log on to **www.mycignaplans.com** using ID: Maricopa2010 and password: cigna

Medical Plan Summary Chart

Benefit Provision:	OAP High:		OAP Low:		Choice Fund:	
Type of Plan *(as licensed)*	HMO with Open Access Specialists (similar to a PPO)				High-deductible PPO plan with partially funded Health Savings Account[1]	
Service Area Where Care Must be Received	Nationally					
Residency Requirement	None					
Primary Care Physician (PCP) Required?	No					
Referral Required?	No					
Out-of-Network Coverage	Yes					
Network	National Open Access AZ300				National Preferred Provider Network AZ011	
Prior Authorization	Provider's responsibility when in-network. Your responsibility when out-of-network. 50% penalty for no prior authorization.					
Per Pay Period (24/yr.) Medical Premiums**	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$46.73	$148.76	$34.62	$95.13	$30.00	$136.80
Employee + Spouse	$104.04	$163.43	$47.80	$102.29	$30.00	$155.01
Employee + Child(ren)	$83.89	$161.53	$39.86	$101.55	$30.00	$150.72
Employee + Family	$141.52	$172.34	$60.98	$105.77	$30.00	$167.37

**The premium will be reduced by $20 per pay period if the entire household (employee and all covered dependents) is tobacco-free for the past six consecutive months; and/or by $5 per pay period for voluntarily participating in the biometric screening initiative; and/or by $5 per pay period for voluntarily participating in the health assessment initiative.

[1]Refer to "**Choice Fund Medical Plan with Health Savings Account**" sub-section on the following page for additional information.

Choice Fund Medical Plan with Health Savings Account

If you are enrolling in the Choice Fund medical plan (also referred to as a high-deductible health plan), generally you are eligible to open and contribute to a Health Savings Account (HSA). There are several rules regarding HSAs, some of which are discussed below.

To open an HSA, you must complete an enrollment package (bank application) which requires your SSN. In order for the bank to verify your enrollment in the Choice Fund medical plan you are required to use your SSN instead of an Alternative ID number.

To qualify for an HSA, you cannot be enrolled in any other type of medical insurance (including Medicare Parts A, B, C or D) and can't be claimed as a dependent on someone else's tax return. (If another taxpayer is entitled to claim an exemption for you, you cannot claim a deduction for an HSA contribution. This is true even if the other person does not actually claim your exemption.)

Maricopa County contributes $500 for employee only coverage or $1,000 for employee and dependent coverage to your HSA pro-rated by the number of months remaining in the plan year at time of enrollment. You can contribute up to $3,050 for CY 2010 and CY 2011 (individual coverage) or $6,150 for CY 2010 and CY 2011 (family coverage) to your HSA, plus $1,000 catch-up if over age 55 minus the County contribution. Maricopa County supports payroll deductions into the JPMorgan Chase account based on your annual contribution amount in the Benefit Enrollment System. Other contributions, such as lump sums, must be handled by you on an after-tax basis outside of payroll. Please note there can be certain tax consequences since your plan year is fiscal instead of calendar, if you enroll and contribute a full year contribution at the end of the first calendar year and do not continue enrollment in Choice Fund for the next 12 months.

Money in your HSA belongs to you, so unused balances are not forfeited at the end of the plan year and are portable if you leave County employment.

You will generally pay medical expenses during the year without being reimbursed by the Choice Fund medical plan until you reach the annual deductible for the plan. When you pay medical expenses during the year that are not reimbursed by the Choice Fund plan, you can ask the trustee of your HSA to send you a distribution from your HSA. You can receive tax-free distributions from your HSA to pay for or be reimbursed for qualified medical expenses you incur after you establish the HSA. If you receive distributions for other reasons, the amount you withdraw will be subject to income tax and may be subject to a tax penalty. The trustee will report any distribution to you and the IRS on Form 1099-SA. If at some point in the future you become ineligible for an HSA, you can still receive tax-free distributions to pay for or be reimburse for qualified medical expenses.

If you enroll in the Choice Fund medical plan and open an HSA, you can also enroll in the Limited Use FSA for reimbursement of qualified dental and vision expenses. If you are a new enrollee in the Choice Fund medical plan, and you are currently enrolled in a Health Care FSA, and you have not used all of the funds in that FSA, then you must incur claims to use up the balance of the funds by June 30. In this unique situation, you will not have a grace period to incur claims because you are not allowed to have both a General Purpose Health Care FSA (not a Limited Use FSA) and an HSA at the same time. Your balance in the Health Care FSA must be zero when the new plan year begins.

Refer to IRS Publications 969 and 502 for further information regarding the rules for opening, contributing to and withdrawing funds from the HSA. You must file IRS Form 8889 when you file your taxes if you had any activity in your HSA during the tax year. It is also advisable to consult with a tax advisor or IRS Tax Advocate at **www.irs.gov/advocate**, or 877-777-4778 or TTY/TDD 800-829-4059, before enrolling in the Choice Fund medical plan and opening a Health Savings Account.

Plan Deductibles & Out-of-Pocket Maximums

Plan Deductibles

Deductibles work differently depending on the type of plan in which you enroll. Refer to the "Medical Copay/Co-Insurance Comparison Chart" for details.

CMG High and Low Plans

- Deductibles for the CMG High and Low plans apply only to facility-based inpatient and outpatient services.
  - Inpatient facilities include a hospital, skilled nursing facility, rehabilitation hospital, hospice facility, and sub-acute facilities.
  - Outpatient facilities include outpatient hospital surgical center and advanced radiological imaging at an outpatient hospital facility for MRI, MRA, CAT and PET scans.
- Individual and Family deductible amounts aggregate. In other words, all covered members can contribute toward the family deductible amount but one person will not be charged more than the individual deductible amount.
- The deductible must be satisfied before any benefits are payable for facility-based services.

OAP Plans

- Deductibles for the OAP Plans apply to any service except physician or specialist office visits, convenience care office visits, preventive care services, and services at an urgent care facility or the emergency room.
- For the OAP High and Low Plans that have out-of-network coverage, there are separate deductibles for in-network services and for out-of-network services. These deductibles accumulate one way (from out-of-network to in-network). In other words, if you meet part or all of your out-of-network deductible, that amount will also be used to meet your in-network deductible. However, this does not work in the reverse.
- Individual and Family deductible amounts aggregate. In other words, all covered members can contribute toward the family deductible but one person will not be charged more than the individual deductible amount.
- The deductible must be satisfied before any benefits are payable except as noted above.

Choice Fund Medical Plan

- Deductibles apply to all services except to preventive medical care and preventive medication on the Drug list.
- The deductible is set at the Individual level, if you elect Individual coverage. The deductible is set at the Family level, if you elect Family coverage.
- Family deductible amounts are collective. In other words, all members contribute to the deductible. In this case, one person could meet the entire Family deductible amount.

- The deductibles cross-accumulates. In other words, if you meet all or part of either your out-of-network or in-network deductible, that amount applies to both your out-of-network or in-network deductibles.
- The deductible must be satisfied before any benefits are payable except as noted above.

Out-of-Pocket Maximums

The out-of-pocket maximums work differently, depending on the type of plan in which you enroll. See details below.

CMG High and Low Plans

The out-of-pocket maximum for the CMG High and Low Plans includes:

- member paid medical co-insurance,
- inpatient facility copays,
- outpatient facility copays, and
- advanced radiological imaging copays.

Other copays, such as pharmacy or behavioral health copays, do not count towards the out-of-pocket maximum. Additionally, the medical plan deductible does not count towards the out-of-pocket maximum.

Once the out-of-pocket maximum is reached, inpatient facility copays, outpatient facility copays and advanced radiological imaging copays will no longer be required for the remainder of the plan year.

Individual and Family out-of-pocket maximum amounts aggregate. In other words, all covered members can contribute toward the family out-of-pocket maximum but one person will not be charged more than the individual out-of-pocket maximum amount.

OAP Plans

The out-of-pocket maximum for the OAP Plans includes:

- member paid medical co-insurance,
- inpatient facility copays,
- outpatient facility copays and
- advanced radiological imaging copays.

Other copays, such as pharmacy or behavioral health copays, do not count towards the out-of-pocket maximum. Additionally, the medical plan deductible does not count towards the out-of-pocket maximum.

Once the out-of-pocket maximum is reached, inpatient facility copays, outpatient facility copays and advanced radiological imaging copays will no longer be required for the plan year.

Individual and Family out-of-pocket maximum amounts aggregate. In other words, all covered members can contribute toward the family out-of-pocket maximum but one person will not be charged more than the individual out-of-pocket maximum amount.

For plans that have out-of-network coverage, the out-of-pocket maximum accumulates one way, from out-of-network to in-network.

Choice Fund Medical Plan

The out-of-pocket maximum for the Choice Fund Medical Plan includes the medical deductible, all copays and all co-insurance including the pharmacy co-insurance.

The out-of-pocket maximum is set at the Individual level, if you elect Individual coverage. The out-of-pocket maximum is set at the Family level, if you elect Family coverage.

The out-of-pocket maximums cross-accumulate between in-network and out-of-network.

Family out-of-pocket maximum amounts are collective. In other words, all members contribute to the out-of-pocket maximum. In this case, one person could meet the entire Family out-of-pocket maximum amount.

Pharmacy Plans

Administered by Walgreens Health Initiatives (WHI)
Rx Bin# 603286/Rx PCN# 01410000

If you (and your dependents) enroll in a County-sponsored medical plan, except for the Choice Fund medical plan, you (and your dependents) must enroll in one of the pharmacy plans below.

Co-insurance Benefit Plan

The Co-insurance benefit is a five-level plan in which a co-insurance amount (percentage of the cost[1] of the medication) is charged (unless the applicable minimum or maximum copay applies) based on the classification of the medication per the Preferred Medication List. This list is available on the EB Home page. This plan covers generic, preferred brand-name, non-preferred brand-name and specialty medications. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% of the cost[1] for excluded medications.

You will be charged the minimum or maximum copay or the co-insurance amount for the medication, based on the medication's level and cost. However, if you choose a non-preferred brand-name medication when a generic equivalent is available, you will also pay the difference in the cost between the generic and non-preferred brand-name medication.

The co-insurance or the minimum or maximum copay for covered medication applies to your out-of-pocket maximum, except when a non-preferred brand name medication with a generic equivalent is purchased, the difference between the brand and the generic equivalent does not count. The out-of-pocket limit is $1,500 for an individual and $3,000 for a family[2]. One person in the family can meet the individual out-of-pocket maximum. Once the applicable out-of-pocket limit is met, covered medications are paid 100% by the plan for the remainder of the plan year, except for the difference between the non-preferred brand and its generic equivalent, which will continue to be your responsibility.

Annual Out-of-Pocket Maximum
$1,500 Individual / $3,000 Family[2]

	Classification	Up to 30-Day Supply		
Level 1	Generic	$2 Minimum	25% Co-insurance[1]	$12 Maximum[3]
Level 2	Preferred Brand	$5 Minimum	30% Co-insurance[1]	$40 Maximum[3]
Level 3	Non-Preferred Brand with Generic equivalent	$40 Minimum	50% Co-insurance[1] +	Difference between NP brand & generic cost
Level 4	Non-Preferred Brand with No Generic equivalent	$40 Minimum	50% Co-insurance[1]	
Level 5	Non-Preferred Brand Specialty Drugs	$50 Copay		

[1]Cost of medication is calculated by average wholesale price minus discount percentage or maximum allowable cost. To find the cost of medication, go to **www.mywhi.com**.

[2]Family refers to employee and one or more covered dependents.

[3]Maximums are reduced when mail service is used.

Per Pay Period (24/yr.) Pharmacy Premiums	Full-Time	Part-Time
Employee	$5.57	$14.96
Employee+Spouse	$11.03	$21.26
Employee+Child(ren)	$8.29	$18.35
Employee+Family	$16.56	$27.05

Consumer Choice Benefit Plan

The Consumer Choice Plan has four levels of coverage:

- Level 1 is a County-funded Pharmacy Account. The County will credit an Individual account with $300 or a Family account (family is defined as more than 1 person covered) with $500. In terms of Family coverage, the $500 is available to whichever family members use the pharmacy benefit on a first come, first served basis.
- Level 2 consists of the Employee Deductible portion and begins when the $300 Individual or $500 Family credit in Level 1 is exhausted. Employees must meet their $300 or $500 deductible before moving to the next level. A family member will move to Level 3 independently, if that individual meets $300 of the $500 amount.
- Level 3 is Traditional Insurance Coverage where the County pays 80% of the cost and you pay the remaining 20% for the remainder of the plan year.
- Level 4 is limited to Specialty Medications for which a $50 copayment is charged. Specialty medication copayments do not apply to Levels 1 - 3.

For further clarification on the Consumer Choice Pharmacy Plan, refer to the Pharmacy Benefit Plan Description found on the EB Home page.

The Consumer Choice benefit is geared towards smart spending through the use of the most cost-effective medication. A preferred medication list (PML) is not used to manage this benefit because much of the management is up to you. Some medications require prior authorization or must be used in a certain order (step therapy). Quantity limits apply for certain medications. Some drug classes, such as infertility, oral non-sedating antihistamines, erectile dysfunction, non-steroidal anti-inflammatory and cosmetic medications, are excluded. You are responsible for paying 100% of the cost[1] for excluded medications.

The amounts you pay toward any covered medication in levels 2 - 4 will apply to your plan year out-of-pocket maximum. The out-of-pocket maximum is $1,500 for individual coverage or $3,000 for family[2] coverage. One person in the family can meet the individual out-of-pocket maximum. Once the applicable out-of-pocket maximum is met, covered prescriptions are paid 100% by the plan for the remainder of the plan year.

Annual Out-of-Pocket Maximum
$1,500 Individual / $3,000 Family[2]

	Certain generic preventive medications are provided at no cost and are not charged or credited against any Levels. The list is available on the EB Home page.			
Level 1	Pharmacy Account	$300 Individual or $500 Family	100% Employer paid[1]	Any unused amount is rolled over to next plan year
Level 2	Employee Deductible	$300 Individual or $500 Family	100% Employer paid[1]	
Level 3	Traditional Insurance Coverage		20%[1] covered by Employee	80%[1] covered by Employer
Level 4	Specialty Medications	$50 copay; does not apply to Levels 1 - 3; rollover amount is not available for specialty medications. Copay applies to out-of-pocket maximum.		

[1]Cost of medication is calculated by average wholesale price minus discount percentage or maximum allowable cost. To find the cost of medication, go to **www.mywhi.com**.

[2]Family refers to employee and one or more covered dependents.

Per Pay Period (24/yr.) Pharmacy Premiums	**Full-Time**	**Part-Time**
Employee	$0.00	$9.17
Employee+Spouse	$0.00	$10.10
Employee+Child(ren)	$0.00	$9.88
Employee+Family	$0.00	$10.50

Co-insurance & Consumer Choice Benefit Plans

Three-month supply at Advantage90 retail pharmacies – When you need maintenance medications for chronic or long-term health conditions, you must purchase a three-month supply at one of the pharmacies in the WHI Advantage90 network or through mail service, after two fills of 30 day (or less) supply at a retail pharmacy. The physician must write your prescription for an 84-91 day supply.

Three-month supply through mail service pharmacy – Prescriptions for maintenance medications for chronic or long-term health conditions can be ordered through the Walgreens Mail Service pharmacy. Besides being convenient, you could save money! Maximum copayments and co-insurance percentages for the Co-insurance plan are reduced when mail service is used. Level 1 (generic) has 15% co-insurance with a maximum of $28, and Level 2 (preferred brand) has 25% co-insurance with a maximum of $70. You must use a specific order form when placing your first order to provide Walgreens Mail Service with important health, allergy and plan information. This form is called the "Tempe Registration and Order Form" and is available online at the EB Home page or at **www.mywhi.com**.

If purchasing medication in a three-month supply is financially problematic, consider enrolling in either the Choice Fund medical plan that uses the CIGNA pharmacy plan and does not require you to purchase maintenance medication in three-month quantities, or enrolling in the Health Care FSA. The Health Care FSA allows you to set aside pre-tax dollars to use for medical-related expenses. A debit card is issued to access those pre-tax dollars and the debit card allows you to pay for your medication in advance of you making your full annual FSA contribution.

Note: A 30-day supply of diabetic medication and supplies may be obtained at a CIGNA Medical Group pharmacy on an ongoing basis. If you are enrolled in any medical plan, except Choice Fund, you will be charged a $10 copay for each prescription. Choice Fund members will be charged according to the Choice Fund plan design. Show your CIGNA medical ID card to purchase your medication and/or supplies in this quantity so that the service will be charged to your medical plan instead of to your pharmacy plan.

Note: You and/or your covered dependents (of any age) may voluntarily enroll in the Maricopa County Diabetic Management Program to qualify for free diabetic medications and supplies, if you have elected either the Co-insurance or Consumer Choice pharmacy plan. Once you or your dependent meets the 9 program requirements, you will receive all covered diabetic medications and supplies free of charge for one year. Annual recertification is required to continue participation. You and/or your covered dependents age 18 and above may also enroll in the Take Charge of Your Diabetes Walgreens Optimal Wellness Program. Upon completion of this year-long educational program, you will be reimbursed for up to 9 diabetic-related office visit copays for one plan year. For information regarding these programs or to request enrollment, please call the Employee Wellness Coordinator at 602-506-3758.

Pharmacy Plan for Choice Fund Medical Plan

Administered by CIGNA
Rx Bin# 600428/Rx PCN# 02150000

If you enrolled in the Choice Fund medical plan, your pharmacy benefit is automatically provided through CIGNA. The CIGNA pharmacy plan uses CIGNA's drug list, available on **www.cigna.com**, and covers medication on a co-insurance basis, usually after the annual deductible is met. Certain medications are excluded and some medications require prior authorization.

The deductible does not apply to any preventive medications. Additionally, generic and preferred-brand preventive medications are provided at no cost. To determine if the medication is classified as preventive, and/or to determine the drug level (generic, preferred brand or non-preferred brand), access the Drug list located on **www.cigna.com** under "Customer Care". Search results show if the medication is preventive (the initials PM will be listed after the name of the medication) and the level to which the medication is assigned.

This plan provides coverage for medication up to a 30-day supply each month when purchased from a participating pharmacy in the CIGNA pharmacy network. A 90-day supply may be purchased through CIGNA Tel-Drug.

The cost of medication may vary by pharmacy. Refer to **www.mycigna.com** for a cost comparison tool located under the "My Plans" tab and then the "Pharmacy" sub-tab. Click on the link "Get a prescription drug price quote" under the "Price a Medication" heading. By clicking this link, you will be able to obtain the cost of your prescription drugs, check for generic drug equivalents, and find out if a specific drug is covered.

Note: Diabetic medication not on the Preventive Medication List and diabetic supplies have a 30%, 40% or 50% co-insurance, after the annual deductible has been met. If the diabetic medication is on the Preventive Medication List and is classified as either generic or preferred-brand name, you will not be charged. If the diabetic medication is on the Preventive Medication List as non-preferred brand name, you will be charged 50% (with no deductible). Insulin pumps and supplies can be purchased through CareCentrix for 10% after the annual deductible has been met. Contact Carecentrix at 800-808-1902.

CIGNA Pharmacy Plan for Choice Fund Medical Plan

Level 1	Generic	30% after deductible
Level 2	Preferred Brand	40% after deductible
Level 3	Non-Preferred Brand	50% after deductible
Generic and preferred-brand preventive medications are provided at no cost. (Annual deductible does not apply to generic, preferred-brand and non-preferred-brand preventive medications).		

There is not a separate premium charge for this plan because it is included in the Choice Fund medical plan premium.

Vision Plan

Administered by EyeMed Vision Care

You will automatically be enrolled in the vision benefit at no additional cost to you if enrolled in a County medical plan. If you waived the County medical plan, you can enroll in the vision plan.

Vision Care Services	In-Network Member Cost	Out-of-Network Reimbursement
Exam with Dilation as Necessary	$10 Copay	$30
Exam Options:		
Standard Contact Lens Fit and Follow-Up*	Up to $40	N/A
Premium Contact Lens Fit and Follow-Up**	10% off retail price	N/A
Frames:		
Any available frame at provider location	$130 allowance, 20% off balance over $130	$50
Standard Plastic Lenses:		
Single Vision	$10 Copay	$25
Bifocal	$10 Copay	$40
Trifocal	$10 Copay	$55
Lenticular	$10 Copay	$55
Lens Options:		
UV Coating	$15	N/A
Tint (Solid and Gradient)	$15	N/A
Standard Scratch-Resistance	$15	N/A
Standard Polycarbonate	$0	Up to $25
Standard Polycarbonate for Children under 19	$0	Up to $25
Standard Anti-Reflective Coating	$45	N/A
Standard Progressive (Add-on to Bifocal)	$75	Up to $40
Premium Progressive	$75, 80% of charge less $120 allowance	Up to $40
Other Add-ons and Services	20% off retail price	N/A
Contact Lenses: *(Contact lens allowance covers materials only)*		
Conventional	$0 Copay, $130 allowance, 15% off balance over $130	$130
Disposables	$0 Copay, $130 allowance; plus balance over $130	$130
Medically Necessary	$0 Copay, Paid-in-Full	$250
LASIK and PRK Vision Correction	$150 allowance; once per lifetime per eye	N/A
Frequency:		
Examination	Once every 12 months	
Frame	Once every 12 months	
Lenses or Contact Lenses	Once every 12 months	

*Standard Contact Lens Fitting - spherical clear contact lenses in conventional wear and planned replacement (Examples include but not limited to disposable, frequent replacement, etc.)

**Premium Contact Lens Fitting - all lens designs, materials and specialty fittings other than Standard Contact Lenses (Examples include toric, multifocal, etc.)

Acute Care Benefit: To enable continuity of eye health care services, an Acute Primary eye care program is available to you at no cost when you use a contracted provider. You are covered for urgent eye care conditions, such as 'pink eye', as well as progressive conditions that result in vision loss. Treatment for chronic conditions such as glaucoma or diabetes (except refraction) must be received through your medical benefit and medical provider.

Additional Discounts

Additional Eyewear - Save up to 40% off additional complete pairs of glasses after the initial benefit has been used. Available at any participating provider.

Eye Care Supplies - Receive 20% off retail price for eye care supplies like cleaning cloths and solutions purchased at participating providers (not valid on doctor's services or contact lenses).

Laser Vision Correction - Save 15% off the retail price or 5% off the promotional price for LASIK or PRK procedures from US Laser Network.

Replacement Contact Lens Purchases - Visit www.eyemedcontacts.com to order replacement contact lenses for shipment to your home at less than retail price.

Per Pay Period (24/yr.) Vision Premiums w/Medical Plan	Full-time	Part-time
Employee	$0.00	$0.00
Employee + Spouse	$0.00	$0.00
Employee + Child	$0.00	$0.00
Employee + Family	$0.00	$0.00

Per Pay Period (24/yr.) Vision Premiums w/o Medical Plan	Full & Part-time
Employee	$5.36
Employee + Spouse	$10.12
Employee + Child	$10.60
Employee + Family	$15.56

For more detail, review the vision plan documents on the EB Home page, or contact EyeMed (refer to "Who to Contact" section).

The information and benefits described herein are brief summaries of the County's official plan documents and contracts that govern the plans. If there is a discrepancy between the information in this booklet and the official documents, the official documents will govern.

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Behavioral Health Plan & Employee Assistance Program

Maricopa County offers both an Employee Assistance Program (EAP) for all employees and their household members, and a Behavioral Health and Substance Abuse plan for employees and their dependents that are enrolled in a County-sponsored medical plan.

Sometimes employees face problems that they cannot solve. Concerns can become overwhelming and affect work performance, personal happiness, family relations and health. When this occurs, professional help may be needed to resolve the problem before it becomes a larger issue. If you are in need of this service, you will be assisted by a behavioral health professional that will ensure your treatment is provided at the most appropriate level of care (EAP or Behavioral Health/Substance Abuse).

For details about the EAP and Behavioral Health benefit, refer to the Magellan EAP brochure, Magellan Behavioral Health Plan Description or the CIGNA Choice Fund Plan Description located on the EBC/ Intranet at http://ebc.maricopa.gov/ehi or on the Internet Web site at **www.maricopa.gov/benefits**.

EAP

The Employee Assistance Program (EAP), offered by Magellan, is an employer-paid benefit for all active employees (not for COBRA participants or retirees) that provides short-term counseling for both personal and work-related issues.

All employees (including contract and temporary) and the members of their household of any age, including domestic partners, elderly parents, stepchildren, and others such as children in college who may be out of state, may use the EAP services.

The EAP provides a full range of counseling and referral services for individual, family and marital concerns, stress and job-related matters, child and domestic abuse, and legal and financial issues. Counseling is available by phone or in person, depending on your preference.

Counseling

The EAP benefit provides up to eight free individual counseling sessions for you and your dependents per person, per problem, per year. If sufficient need is shown, upon your approval, your counselor may encourage other members of your family to participate. Magellan provides the strictest confidentiality possible, as set forth in state and federal statutes. Release of information by the EAP concerning an individual can be given only with your written consent, except where required by law (e.g., when child abuse is suspected or when posing a danger to self or others).

Legal Consultation

Your EAP provides legal consultation services. You can call and be referred to an attorney for a prepaid initial in-person consultation or you can call and receive immediate telephonic consultation on issues such as estate planning, family and divorce law, civil and criminal matters, and more.

Financial Counseling

Your EAP also includes services to help you reach your financial goals. When you call, you will be put in touch with a financial expert who can provide information and answer questions on a wide range of topics, including planning for retirement, debt consolidation, and more.

For more information regarding the EAP or to make an appointment, contact Magellan 24 hours a day, seven days a week. Refer to the "**Who to Contact**" section.

Behavioral Health and Substance Abuse

The Behavioral Health benefit is limited to employees and their dependents that have enrolled in a CIGNA medical plan. If you are enrolled in the Choice Fund medical plan, your behavioral health and substance abuse benefits are provided by CIGNA Behavioral Health. If you are enrolled in any of the other five CIGNA medical plans, your behavioral health and substance abuse benefits are provided by Magellan.

The behavioral health benefit provides services that support your well-being. These services help you deal with a wide range of issues, including:

- Anger management
- Depression
- Eating disorders
- Grief and loss
- Severe stress and anxiety
- Substance abuse

Through these services, you receive confidential counseling whenever you and/or your eligible dependents are faced with a personal challenge All records, including personal information, referrals and evaluations, are kept confidential in accordance with federal and state laws.

For more information regarding the Behavioral Health and Substance Abuse benefit, contact Magellan or CIGNA Behavioral Health, 24 hours a day, seven days a week. Refer to "**Who to Contact**" section.

Magellan Behavioral Health and Substance Abuse Benefits

If you are enrolled in one of the following CIGNA medical plans, this sub-section applies to you.

CMG High	OAP High
CMG Low	OAP Low
OAP In-network	

This benefit includes coverage through providers who participate in the Magellan provider network (in-network) as well as limited coverage through providers who do not participate in the Magellan network (out-of-network). From a cost perspective, it is always to your advantage to receive services from in-network providers because you will pay less for the service. This is because Magellan has a contract with the providers in their network to provide a discount off the amount they would normally bill. With out-of-network providers, Magellan pays set dollar amounts depending on the service. You will be billed for the difference.

To find a participating provider in Magellan's network, visit Magellan's Web site or call Magellan.

All in-network services require prior approval by Magellan before services are received. Higher levels of care for out-of-network providers (such as inpatient, residential, intensive outpatient, and partial hospitalization) also require prior approval. However, out-of-network outpatient individual or group counseling services do not.

Level of Care	In-Network Benefit	In-Network Rules	Out-of-Network Benefit	Out-of-Network Rules
Inpatient Hospitalization	30 days per year are shared between in and out-of-network benefits $25 copay per day	Preauthorization required	30 days per year are shared between in and out-of-network benefits $500 deductible Plan pays $250 per day after deductible is met. All other costs after plan payment of $250 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain pre-authorization results in no reimbursement
Partial Hospitalization	Benefit is derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial day per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day $20 copay per day	Preauthorization required	Benefit derived from trading unused inpatient hospitalization days for up to 30 partial hospitalization days per year 30 partial days per year are shared between in and out-of-network benefits Trade at 2 partial days for 1 inpatient day $250 deductible Plan pays $125 per day after deductible. All costs after plan payment of $125 are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
Residential	60 days per year $12.50 copay per day	Preauthorization required	No benefit	N/A
Intensive Outpatient (IOP)	45 IOP visits per year are shared between in and out-of-network benefits $100 copay per program	Preauthorization required $100/program copay applies to a continuous episode of care in IOP. If patient discontinues & restarts program, a new $100 copay is applied	45 IOP visits per year are shared between in and out-of-network benefits Plan pays $40 per visit. All other costs after plan payment of $40 per visit are member's responsibility	Preauthorization required It is the member's responsibility to obtain preauthorization for initial and concurrent reviews Failure to obtain preauthorization results in no reimbursement
Outpatient therapy (individual, family, and medication evaluation)	Unlimited visits per year $20 copay per visit	Preauthorization required	Unlimited visits per year Plan pays $25 per visit. All other costs after plan payment of $25 per visit are member's responsibility	No preauthorization
Outpatient Group Psychotherapy	Unlimited visits per year $5 copay per visit	Preauthorization required	Unlimited visits per year Plan pays $15 per visit. All other costs after plan payment of $15 per visit are member's responsibility	No preauthorization
Ongoing Medication Management	$10 copay per visit Not subject to outpatient visit limits	Preauthorization required	Plan pays $25 per visit. All other costs after plan payment of $25 per visit are member's responsibility Not subject to outpatient visit limits	No preauthorization
Lifetime Maximums	No lifetime maximum		$5 million lifetime maximum	
Annual Limits:	Autism coverage is limited to $115,000 per plan year through age 9 and $50,000 per plan year between the ages of 10-18.			

The premium for the behavioral health benefit is included in the medical premium.

CIGNA Behavioral Health and Substance Abuse Benefits

If you are enrolled in the Choice Fund medical plan, this sub-section applies to you.

This benefit includes coverage through providers who participate in the CIGNA provider network (in-network) as well as limited coverage through providers who do not participate in the CIGNA network (out-of-network). From a cost perspective, it is always to your advantage to receive services from in-network providers because you will pay less for the service. This is because CIGNA has a contract with the providers in their network to provide a discount off the amount they would normally bill. With out-of-network providers, CIGNA pays the Reasonable and Customary charge, after the annual deductible has been met. You will be billed for the difference.

When receiving services from a provider within the CIGNA network, only inpatient hospitalization requires prior authorization. The in-network admitting provider will obtain prior authorization on your behalf. All other services received in-network are on a self-referral basis. To locate a participating provider, use the online CIGNA provider directory.

All out-of-network services require prior authorization. When you go out-of-network, it is your responsibility to obtain prior authorization before receiving services. Contact CIGNA to begin the authorization process.

Mental Health and Substance Abuse	In-network Benefit	Out-of-network Benefit
Inpatient	10% after plan deductible; 60 days combined maximum per plan year	30% after plan deductible; 60 days combined maximum per plan year
Outpatient	10% after plan deductible; unlimited visits per plan year	30% after plan deductible; unlimited visits per plan year
Outpatient Group Therapy Mental Health (MH) *(One group therapy session equals one individual therapy session)*	10% after plan deductible	Subject to the same co-insurance and medical plan deductible as Outpatient MH visits
Intensive Outpatient Mental Health *Maximum: Up to 3 programs per plan year based on ratio of 1:1 with outpatient MH visits*	50% after plan deductible	50% after plan deductible
Annual Limits:	Autism coverage is limited to $115,000 per plan year through age 9 and $50,000 per plan year between the ages of 10-18.	

The premium for the behavioral health benefit is included in the medical premium.

Combined Rate Sheet

Per Pay Period Total Medical Premiums deducted 24 times/plan year
(Includes Medical, pharmacy, behavioral health, vision)

Reduce $20 per tobacco free household (employees and covered dependents)
Reduce $5 if the employee voluntarily participates in the biometric screening initiative
Reduce $5 if the employee voluntarily participates in the health assessment initiative

CMG High option + Co-insurance Rx	Full-time	Part-time
Employee	$42.75	$147.52
Employee + Spouse	$67.42	$163.73
Employee + Child(ren)	$52.80	$157.55
Employee + Family	$92.14	$174.40

CMG High

CMG High option + Consumer Choice Rx	Full-time	Part-time
Employee	$37.18	$141.73
Employee + Spouse	$56.39	$152.57
Employee + Child(ren)	$44.51	$149.08
Employee + Family	$75.58	$157.85

CMG Low option + Co-insurance Rx	Full-time	Part-time
Employee	$40.23	$109.06
Employee + Spouse	$59.08	$125.82
Employee + Child(ren)	$48.17	$120.42
Employee + Family	$77.30	$133.62

CMG Low

CMG Low option + Consumer Choice Rx	Full-time	Part-time
Employee	$34.66	$103.27
Employee + Spouse	$48.05	$114.66
Employee + Child(ren)	$39.88	$111.95
Employee + Family	$60.74	$117.07

OAP In-Network + Co-insurance Rx	Full-time	Part-time
Employee	$51.67	$160.57
Employee + Spouse	$115.60	$180.50
Employee + Child(ren)	$91.42	$173.85
Employee + Family	$157.18	$192.03

OAP-IN

OAP In-Network + Consumer Choice Rx	Full-time	Part-time
Employee	$46.10	$154.78
Employee + Spouse	$104.57	$169.34
Employee + Child(ren)	$83.13	$165.38
Employee + Family	$140.62	$175.48

OAP High option + Co-insurance Rx	Full-time	Part-time
Employee	$52.30	$163.72
Employee + Spouse	$115.07	$184.69
Employee + Child(ren)	$92.18	$179.88
Employee + Family	$158.08	$199.39

OAP High

OAP High option + Consumer Choice Rx	Full-time	Part-time
Employee	$46.73	$157.93
Employee + Spouse	$104.04	$173.53
Employee + Child(ren)	$83.89	$171.41
Employee + Family	$141.52	$182.84

OAP Low option + Co-insurance Rx	Full-time	Part-time
Employee	$40.19	$110.09
Employee + Spouse	$58.83	$123.55
Employee + Child(ren)	$48.15	$119.90
Employee + Family	$77.54	$132.82

OAP Low

OAP Low option + Consumer Choice Rx	Full-time	Part-time
Employee	$34.62	$104.30
Employee + Spouse	$47.80	$112.39
Employee + Child(ren)	$39.86	$111.43
Employee + Family	$60.98	$116.27

Choice Fund HSA + CIGNA Rx	Full-time	Part-time
Employee	$30.00	$136.80
Employee + Spouse	$30.00	$155.01
Employee + Child(ren)	$30.00	$150.72
Employee + Family	$30.00	$167.37

Choice Fund HSA

Dental Plan Summary Chart

Administered by:	Employers Dental Solutions (EDS)		CIGNA Dental*		Delta Dental**	
Type of Plan	DCO (Dental Care Organization)		PPO		PPO (but does not use PPO network; see network below.)	
Service Area Where Care Must be Received	Maricopa County		National		National	
Residency Requirement	No		No		No	
Primary Care Dentist Required	Yes, all family members must choose the same dentist		No		No	
Referral Required	No		No		No	
Out-of-Network Coverage	No		Yes		Yes	
Network	EDS Provider Network		CIGNA Dental Network		Delta Premier Network	
Prior Authorization	No		No, predetermination recommended for services over $250		No, predetermination recommended for services over $250	
Location of Provider Directory	www.mydentalplan.net		www.cigna.com		www.deltadentalaz.com	
Per Pay Period (24/yr.) Dental Premiums	**Full-time**	**Part-time**	**Full-time**	**Part-time**	**Full-time**	**Part-time**
Employee	$2.16	$2.16	$7.23	$12.02	$13.71	$18.50
Employee + Spouse	$4.10	$4.10	$15.95	$27.45	$30.25	$41.75
Employee + Child(ren)	$5.38	$5.38	$17.25	$28.37	$32.71	$43.83
Employee + Family	$6.18	$6.18	$22.18	$37.48	$42.06	$57.36

*Includes the CIGNA Dental Oral Health Integration Program®.
**Includes enhanced dental benefits for pregnant women and persons with diabetes.

For more information about these dental wellness programs, see the "Wellness Initiatives and Incentives" section.

Dental Copay/Co-insurance Comparison Chart

Benefit Provision		EDS*	CIGNA Dental***		Delta Dental	
		In-Network coverage only	In and Out-of-Network coverage			
Deductible	Individual	$0	$50		$50	
	Family	$0	$100		$100	
Annual Individual Benefit Maximum	Standard	None	$2,000		$2,000	
	Orthodontic	None	$3,000		$3,000	
Pre-existing Condition Limitation		Procedures in progress at time of enrollment are not covered	5 year waiting period for replacement (major services)		5 year waiting period for replacement (major services)	
Class I - Preventive Care Services			**Amount Paid by the Member**			
Preventive Care		$0	In-Network	Out-of-Network**	In-Network	Out-of-Network**
Routine Cleanings		$12/tooth	Deductible waived			
Sealants		$20 + lab fees	$0	20%	$0	$0
Space Maintainers						
Diagnostic		$0-$15	Deductible waived			
Exams			$0	20%	$0	$0
Evaluations						
Consultations & X-rays						
Emergency		Up to $200 reimbursement less applicable copay	Deductible waived			
Palliative Treatment			$0	20%	$0	$0
Treatment for the relief of pain						
Class II - Basic Restorative Services			**Amount Paid by the Member**			
Restorative		Amalgam $9-$21	Amalgam 20%	Amalgam 40%	Amalgam 20%	Amalgam 20%
Fillings		Resin $22-$52	Resin 50%	Resin 50%	Resin 50%	Resin 50%
Oral Surgery			20%	40%	20%	20%
Extractions		$35 - $120				
Endodontics			20%	40%	20%	20%
Root Canal Treatment		$170 - $265				
Pulpotomy		$30 - $85				
Periodontics			20%	40%	20%	20%
Treatment of gum disease		Debridement: $80				
Periodontal Maintenance		Root Planing: $90/quadrant				
Bridge & Denture Repair		$10 + lab fees	20%	40%	20%	20%
Class III - Major Restorative Services			**Amount Paid by the Member**			
Prosthodontics			50%		50%	
Bridges per pontic		$250 + lab fees				
Partial Dentures		$375 + lab fees				
Complete Dentures (upper or lower)		$325 + lab fees				
Restorative			50%		50%	
Cast Crowns & Jackets		$250 + lab fees				
Onlays & Inlays		$135 - $170				
Class IV - Orthodontic Services			**Amount Paid by the Member**			
Orthodontic maximum is separate from annual benefit maximum		25% discount adults & children	50% adults & children		50% adults & children age 8 + older	

*Specialist Care & treatment of TMJ are offered at a discount.

**If the dentist charges more than the reasonable & customary allowance, you will be liable for the difference between the allowance and the billed amount, in addition to the applicable deductible and co-insurance.

***Progressive/Regressive Base Plan effective July 1, 2008. If you enroll in this plan and you or your covered dependents receive a preventive service during the plan year, the level of coverage is increased for that person by 5% for Class II and Class III services for the next plan year up to a 10% maximum. If you don't receive a preventive service during the plan year, the level of coverage is decreased by 5% for these services for the next plan year. However, level of coverage will not go below that listed above.

For more detail, review the dental plan documents on the **Employee Benefits Dental Page**, or contact the vendor (refer to "**Who to Contact**" section).

How to Look up a Provider Online

CIGNA Medical and Dental Plans – Start at www.cigna.com

Look for the Tree of Life symbol to identify CIGNA Care Network Specialists to receive a $15 discount on your specialist copay. Refer to the "Medical Plans" section, for more information.

1. From the home page, select the Provider Directory link under "Locate" at top left.
2. For medical, select the radio button next to Physician and enter your physician search information.
   For dental, select the radio button next to Dentist and enter the dentist search information.
3. Click on the "Next" button.
4. Continue with the applicable instructions below.

CMG High and Low Options use the AZ – CIGNA Medical Group Network AZ812

1. On the next page, under "What type of plan do you have?" section, select the radio button next to "Network, HMO, POS".
2. From the "Select Healthplan Network" drop-down list, select AZ-CIGNA Medical Group.
3. Under "What you're looking for" section, select the radio button next to "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list.
4. Click on the "Search" button to view the provider search response.

OAP In-Network and OAP High and Low Options use the National Open Access Plus Network AZ300

1. On the next page, under the "What type of plan do you have?" section, select the radio button next to "Open Access Plus, OA Plus, Choice Fund OA Plus".
2. Under "What you're looking for" section, select the radio button next to "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list.
3. Click on the "Search" button to view the provider search response.

Choice Fund Health Savings Account (HSA) use the National Preferred Provider Network AZ011

1. On the next page, under "What type of plan do you have?" section, select the radio button next to "PPO, Choice Fund PPO".
2. Under "What you're looking for" section, select the radio button next to "Primary Care Physician" or "Specialist" and the type from the corresponding drop-down list.
3. Click on the "Search" button to view the provider search response.

CIGNA Dental

1. On the next page, under "What type of plan you have" section, choose "CIGNA Dental PPO or CIGNA Dental EPO" and select "Core Network" from the drop-down list. Click on the "Search" button to view the dental search response.

Other Dental Plans

EDS

1. Start at **www.mydentalplan.net**
2. From the home page, click "Find a Dentist". Or you can choose to print a provider directory.
3. You can search by dentist, location, office name, or specialty. On the home page you can also print a provider directory.

Delta Dental

1. Start at **www.deltadentalaz.com**
2. Click on Dentists and then Dentist Search
3. When a new page appears, under "1. Product Selection", select "Dental Premier" and continue entering the identifying information
4. Or call 602-938-3131 and select 5 and enter the zip code to hear a listing of dentists in your area

VISION PLAN

EyeMed Vision Care

1. Start at **www.eyemedvisioncare.com**
2. From the Home page, in the left menu section, click on the drop-down box labeled "Select Your Network" and choose the "Select" option.
3. Enter your zip code where indicated and click the "Submit" button
4. A new window will open and ask you to enter text in the box, click the "Submit" button after entering the text.

Life Insurance Plan

Fully Insured by The Standard
Policy Number: 645547

Your Basic and Additional Life insurance, Basic and Additional Accidental Death and Dismemberment insurance, and Dependents Life insurance benefits are provided through The Standard Insurance Company ("The Standard"). Evidence of Insurability (EOI) may be required in certain situations. Once you purchase Additional Life or Dependents Life insurance, you can reduce it or cancel it at any time.

Basic Term Life and Basic Accidental Death & Dismemberment Insurance

The County provides you with, and pays for, Basic Term Life insurance and Basic Accidental Death and Dismemberment (AD&D) insurance equal to your base annual salary (excluding overtime, bonus, commissions, or special work assignment pay and including management and professional assignment pay) rounded up to the next highest $1,000 to a maximum of $500,000. Coverage becomes effective on the date an elected official becomes eligible for benefits, and on the first day of the calendar month following the date any other employee becomes eligible for benefits. Life insurance benefits are paid for any cause of death. In addition to the death benefit, Basic AD&D benefits up to the amount of Basic Life coverage may be payable if an accident is the cause of death or if a dismemberment occurs. EOI is not required for Basic Life and Basic AD&D coverage (except if you were eligible under the prior life insurance plan with Unum Life Insurance Company for more than 31 days but were not insured).

Additional Life Insurance

If you want to increase your Basic Life insurance coverage, you can apply for Additional Life insurance.

The amount of your life insurance coverage may not exceed $1 million of Basic Life and Additional Life combined or Basic AD&D and Additional AD&D combined.

If you purchase Additional Life insurance at the time you are a new hire or when first eligible, you may elect coverage in amounts of 1, 2, 3, 4 or 5 times your base annual salary rounded up to the next $1,000 up to the GIA of $500,000. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved.

If you didn't enroll in Additional Life insurance as a new hire or when first eligible, you may apply for any level of coverage (1, 2, 3, 4 or 5 times your annual salary) at any time, but EOI is required to be approved by The Standard before coverage becomes effective.

If you have a qualified status change, you can, within 30 calendar days of that change, enroll in or increase Additional Life coverage (1, 2, 3, 4 or 5 times your base annual salary) without EOI, unless the requested amount is greater than the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved. If your EOI application for an increase in coverage is not approved, your coverage will be increased to the next level as long as that level does not exceed the GIA. To learn what constitutes a qualified status change, refer to the "**What is a qualified status change?**" sub-section.

During an Open Enrollment period, you can increase your Additional Life coverage by one level without EOI, provided the increased amount does not exceed the GIA. If you increase your coverage by more than one level or if the increase is over the GIA, you must complete an EOI application. If you do not complete the EOI application, or if your EOI application is not approved, your coverage will be increased to the next level, as long as that level does not exceed the GIA.

Evidence of Insurability

When EOI is required, the "Medical History Statement" form must be completed. The "Medical History Statement" form is available at **www.standard.com/mybenefits/maricopa**. Once the form is completed, it must be submitted to The Standard who will review the information and make a determination whether to approve or deny your request for coverage. The Standard may request further information, such as medical records, when making a determination. Coverage and the associated premium do not become effective until The Standard approves your request. For new hires, the effective date of coverage is the first day of the pay period next following the date your application is approved. Other approved increases are effective the first day of the calendar month next following the date your application is approved, or the following July 1 if you apply during an Open Enrollment period.

Life Features

- Repatriation
  - Available when death occurs more than 75 miles from the insured's primary residence
  - Reimburses the lesser of 2% of life benefit (Basic and Additional) or $2,500, for transportation of an insured's remains to a mortuary near the primary residence
- Accelerated Benefit
  - Applies to insured who is terminally ill with 12 or less months to live
  - Limited to 50% of Basic and Additional life
- Assignment
  - Benefits are not assignable

Medex® Travel Assist Benefit - Group# 7088

Medex® is a comprehensive program of information, referral, assistance, transportation and evacuation services when eligible members are traveling more than 100 miles from home or in a foreign country. The Medex brochure, which contains the ID card, is posted on the Employee Benefits Web site and on The Standard's Web site.

- Services
  - Pre-Trip assistance
  - Medical assistance
  - Emergency transportation services
  - Travel assistance
  - Personal security
  - Medical supplies
- Eligibility
  - Any Maricopa County employee covered by The Standard's Group Life insurance plan and his/her eligible dependents (spouse and/or unmarried dependent children under age 19 or through age 24 if a full-time student)

Special Rate for Non-Tobacco Users

As part of the County's commitment to good health, a reward is offered for leading a healthier lifestyle. If you are not a tobacco user, your life insurance premiums are lower than those of an employee who uses tobacco.

5 Year Age Categories *(Age on last January 1)*	Employee Cost Monthly per $1,000 of Coverage *(Non-Tobacco User Multiplier)*	Employee Cost Monthly per $1,000 of Coverage *(Tobacco User Multiplier)*	*Smoker rates are controlled by your response to tobacco-use questions on the Additional Life Plan page in the Benefit Enrollment System. It is your responsibility to ensure that these questions are answered accurately.* *Misstatement of your tobacco use status may result in the life insurance company rescinding coverage at the time of death.*
Under 25	$0.040	$0.065	
25-29	$0.047	$0.070	
30-34	$0.062	$0.080	
35-39	$0.070	$0.136	
40-44	$0.092	$0.194	
45-49	$0.150	$0.385	
50-54	$0.230	$0.709	
55-59	$0.390	$0.722	
60-64	$0.660	$1.120	
65-69	$0.950	$1.370	
70 and older	$1.760	$2.250	

Additional Life Insurance Premium Calculator Example

If you are enrolling online through the Benefit Enrollment System, the system calculates your premium automatically.

Take your base annual salary - **example: $24,500**					
Round up to the nearest $1,000	$25,000	$25,000	$25,000	$25,000	$25,000
Multiply by coverage level	1x Salary	2x Salary	3x Salary	4x Salary	5x Salary
Salary amount	$25,000	$50,000	$75,000	$100,000	$125,000
÷ divided by $1,000	**25**	**50**	**75**	**100**	**125**

Refer to the Additional Life Insurance table above to find your age category and tobacco-user or non-tobacco user multiplier

Multiply the result (25, 50, 75, 100, or 125) from the last calculation in the table above by the applicable age and tobacco/non-tobacco user multiplier; then divide by 2 to calculate the per pay period premium (24/yr.)

Example: Age 37	**Multiplier for Non-Tobacco User $0.070**	**Multiplier for Tobacco User $0.136**	**Coverage Amount**
1x Salary	$0.070 x 25 = $1.75/2 = $0.88	$0.136 x 25 = $3.40/2 = $1.70	$25,000
2x Salary	$0.070 x 50 = $3.50/2 = $1.75	$0.136 x 50 = $6.80/2 = $3.40	$50,000
3x Salary	$0.070 x 75 = $5.25/2 = $2.63	$0.136 x 75 = $10.20/2 = $5.10	$75,000
4x Salary	$0.070 x 100 = $7.00/2 = $3.50	$0.136 x 100 = $13.60/2 = $6.80	$100,000
5x Salary	$0.070 x 125 = $8.75/2 = $4.38	$0.136 x 125 = $17.00/2 = $8.50	$125,000

Additional AD&D Benefits

You may purchase Additional AD&D insurance from The Standard. With Additional AD&D insurance, you or your beneficiaries may be eligible to receive an additional amount in the event of death or dismemberment as a result of an accident.

Eligible employees may choose Additional AD&D coverage of 1, 2, 3, 4 or 5 times their base annual salary, rounded to the next $1,000. The maximum amount is $500,000.

You may elect Additional AD&D coverage for yourself only as individual coverage, or you may elect family coverage for you and your spouse and/or child(ren). If you elect family coverage, the amount of AD&D coverage for your spouse and child(ren) will be a percentage of your Additional AD&D insurance as follows:

- Spouse only: 60%
- Child(ren) only: 10% for each child, not to exceed $25,000
- Spouse and child(ren): 50% for your spouse; 5% for each child

You are not required to elect Additional Life insurance in order to elect Additional AD&D.

Voluntary Accidental Death & Dismemberment Family Monthly Cost
$0.035 per $1,000
Employee Only Cost
$0.02 per $1,000

Other Additional AD&D benefit features are listed below:

- Seat Belt
  - Lesser of $25,000 or 10% of AD&D benefit payable for loss of life
    - Applies to an insured driver or passenger as evidenced by police report
- Airbag
  - Lesser of $15,000 or 5% of the AD&D benefit payable for loss of life
    - Applies if seat belt benefit is payable for an insured driver or passenger in position to be protected by airbag as evidenced by police report
- Career Adjustment
  - Lesser of $10,000 or 25% of AD&D benefit; $5,000 per year maximum
    - Payable to surviving spouse
    - Pays tuition expense up to three years after death
- Child Care
  - Maximum of 3% of the amount of the AD&D benefit up to a $2,000 per year maximum
    - Payable to surviving spouse for eligible child(ren)
    - Pays child care expenses (for a licensed provider) up to 72 months after death
- Higher Education
  - Lesser of $40,000 or 25% of AD&D benefit; $10,000 per year maximum
    - Available to surviving child(ren) at or near high school/college age
    - Pays tuition expense up to four years after member's death
- Line of Duty
  - Lesser of $50,000 or 100% of the amount of AD&D benefit payable for the loss of insured public safety officer (does not include corrections, probation, parole or judicial officers)
- Occupational Assault
  - Lesser of $25,000 or 100% of the amount of AD&D benefit payable for the loss if assaulted while actively at work as evidenced by police report

- Public Transportation
  - Lesser of $200,000 or 100% AD&D benefit payable for loss by a fare paying passenger on public transportation

AD&D Exclusions

AD&D benefits are not payable for death or dismemberment caused or contributed by:

- War or acts of war;
- Suicide or other intentionally self-inflicted injury;
- Injuries sustained while committing or attempting to commit a felony;
- Any drug not used in accordance to the directions of a physician;
- Sickness, pregnancy, heart attack or stroke;
- Medical or surgical treatment for any of the above;
- Boarding, leaving, or being in or on any kind of aircraft. However, this exclusion will not apply if the person who suffers the loss is a fare paying passenger on a commercial aircraft.
- Any loss caused by an accident which arises out of or in the course of any employment for wage or profit.

Dependents (Child and Spouse) Life Coverage

You may elect Dependents life insurance for your eligible dependents (legal spouse and children).

Note: You may not cover your spouse as a dependent if he or she is enrolled for basic life coverage as a Maricopa County employee. Additionally, if you and your spouse are both County employees, only one may enroll dependent children for coverage. These enrollment rules are not monitored by the County because our system does not have an indicator advising if two County employees are married to each other. It is therefore your responsibility to properly enroll in dependents life insurance. Premiums paid for coverage of ineligible dependents will not be reimbursed if you fail to comply with these enrollment requirements. Coverage will be limited to one policy as determined by The Standard.

Child Life

Child Life coverage may be purchased for the employee's dependent child(ren) from live birth to age 19, or to age 25 if a full-time student. Coverage may also be purchased for a continuously disabled child(ren). You must provide proof of disability to The Standard within 30 days after a) the date insurance would otherwise end because of the child's age or b) the effective date of Maricopa County's coverage under The Standard's policy, if your child is disabled on that date. Contact The Standard to obtain the appropriate form to complete for a disabled child.

The amount of Child Life insurance coverage may not exceed the lesser of $20,000 or the total amount of the employee's life insurance (Basic and Additional combined). Coverage is available in increments of $5,000. EOI is required for Child Life coverage amounts greater than the GIA of $10,000.

If you purchase Child Life insurance at the time you are a new hire or when first eligible, you may elect coverage in amounts up to the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved.

If you didn't enroll in Child Life insurance as a new hire or when first eligible, you may apply for any level of coverage at any time, but EOI is required to be approved by The Standard before coverage becomes effective.

If you have a qualified status change, you can, within 30 calendar days of that change, enroll in or increase Child Life coverage without EOI, unless the requested amount is greater than the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved. If you EOI application for an increase in coverage is not approved, your coverage will be increased to the next level as long as that level does not exceed the GIA. To learn what constitutes a qualified status change, refer to the "**What is a qualified status change?**" sub-section.

Children (live birth to 25 years if full-time student)	
Monthly Cost (for one or more children)	Coverage Amount
$0.50	$5,000
$1.00	$10,000
$1.50	$15,000
$2.00	$20,000

During an Open Enrollment period, new enrollment or any increase in your Child Life coverage requires EOI.

Spouse Life

Spouse Life coverage may be purchased for the employee's legal spouse.

The premium for Spouse Life coverage is based on the age of the spouse as of January 1 of the current year. In order for the premium to calculate accurately you must ensure that your spouse's age is included on the dependent record in the Benefit Enrollment System. **Note**: When enrolling in the Benefit Enrollment system initially, the spouse life premium calculates on your age, however, when the final calculation occurs and the Confirmation Statement is produced, the correct spouse life premium will display.

The amount of Spouse Life insurance coverage may not exceed the lesser of $100,000 or the total amount of the employee's life insurance (Basic and Additional combined). Coverage is available in increments of $10,000. EOI is required for Spouse Life coverage amounts greater than the GIA of $50,000.

If you purchase Spouse Life insurance at the time you are a new hire or when first eligible, you may elect coverage in amounts up to the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved.

If you didn't enroll in Spouse Life insurance as a new hire or when first eligible, you may apply for any level of coverage at any time, but EOI is required to be approved by The Standard before coverage becomes effective.

If you have a qualified status change, you can, within 30 calendar days of that change, enroll in or increase Spouse Life coverage without EOI, unless the requested amount is greater than the GIA. EOI is required for an amount greater than the GIA. If you elect more than the GIA, you will be enrolled for coverage up to the GIA until your EOI application for the amount in excess of the GIA is approved. If you EOI application for an increase in coverage is not approved, your coverage will be increased to the next level as long as that level does not exceed the GIA. To learn what constitutes a qualified status change, refer to the "**What is a qualified status change?**" sub-section.

Spouse Life - Monthly Cost	
Age on last January 1	**Spouse**
Under 25	$0.066/$1,000
25-29	$0.077/$1,000
30-34	$0.088/$1,000
35-39	$0.110/$1,000
40-44	$0.132/$1,000
45-49	$0.220/$1,000
50-54	$0.374/$1,000
55-59	$0.594/$1,000
60-64	$0.990/$1,000
65-69	$1.410/$1,000
70 and older	$2.290/$1,000

During an Open Enrollment period, new enrollment or any increase in your Spouse Life coverage requires EOI.

Claims Process

Claims must be filed no later than one year after the 90 days immediately following the date of loss. When filing a death claim, a certified death certificate is required. Please contact the Maricopa County Employee Benefits Division in the event of a loss of life or an accidental dismemberment. A Benefits Analyst will assist with providing the Beneficiary Statement form to the beneficiary and completing the Proof of Death form.

Summary of Coverage

Coverage	Who is Covered?	Minimum	Maximum	Evidendence of Insurability	Who pays premium?	Monthly Premium
Basic Life	Employee Only	1 x salary	$500,000	None	Maricopa County	.10/1,000
Basic AD&D	Employee Only	1 x salary	$500,000 (matches Basic Life amount)	None	Maricopa County	.02/1,000
Additional Life[1]	Employee Only	1 x salary	5 x salary to a combined total of $1M (Basic + Additional) at new hire, newly eligible or status change. May only increase 1 level during Open Enrollment.	>$500,000 or late applicant	Employee	Based on tobacco use status & age as of Jan. 1
Spouse Dependents Life	Legal Spouse of Employee	$10,000	$100,000 but not more than employee's combined Basic + Additional.	>$50,000, late applicant, or enrollment or increase at Open Enrollment.	Employee	Based on spouse's age as of Jan. 1
Child(ren) Dependents Life	Child(ren) as defined in the group policy	$5,000	$20,000 per child, but not more than employee's combined Basic + Additional per child.	>$10,000, late applicant, or enrollment or increase at Open Enrollment.	Employee	.10/1,000 (for one or more children)
Employee Only (Individual) Additional AD&D[1]	Employee Only	1 x salary	5 x salary to a maximum of $500,000	Does not apply to AD&D	Employee	.02/1,000
Family Additional AD&D[2]	Employee, Spouse and Child(ren)	1 x salary	5 x salary to a maximum of $500,000	Does not apply to AD&D	Employee	.035/1,000

[1]Employee does not have to enroll in Additional Life in order to purchase Additional AD&D

[2]Family coverage includes employee and/or legal Spouse and/or Child(ren). Employee may not be insured for Employee Only Additional AD&D coverage and Family Additional AD&D coverage concurrently. Family coverage amounts are a) 60% of employee's Additional AD&D amount when only a Spouse is covered; b) 10% of employee's Additional AD&D amount up to $25,000 maximum when only a Child(ren) is covered; and c) 50% of employee's Additional AD&D amount for a Spouse and 5% for each Child when both Spouse and Child(ren) are covered.

Portability

If your group coverage ends due to employment termination or retirement, you may be eligible for portable group Life, AD&D and Dependents Life coverage. The portable insurance is available for up to your current coverage amount up to $300,000 for Life and AD&D combined, $100,000 for spouse, and $5,000 for child(ren); or you may decrease the amount of your coverage to the minimum amounts listed in the "Coverage Features" section of the policy.

To apply, contact The Standard within 45 calendar days after your group insurance coverage ends.

Conversion

If you are not eligible for portable coverage, you or your dependents may qualify for conversion coverage.

To apply, contact The Standard within 45 calendar days after your group insurance coverage ends.

Waiver of Premium Benefit

Insurance (all insurance except AD&D) will be continued without payment of premiums while you are Totally Disabled if:

- You become Totally Disabled while insured under the Group Policy and are under age 60;
- Your period of Total Disability will last 180 consecutive days; and
- You provide a satisfactory Proof of Loss.

Totally Disabled means that, as a result of sickness, accidental injury, or pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

Waiver of premium ends on the earliest of:

- The date you cease to be Totally Disabled;
- 90 days after the date The Standard mails you a request for additional Proof of Loss, if it is not given;
- The date you fail to attend an examination or cooperate with an examiner;
- The date you reach age 65.

It is your responsibility to notify the Employee Benefits Division when you no longer meet the eligibility criteria listed above so that the waiver of premium benefit can be stopped.

Contact Employee Benefits to apply for this benefit. If approved, the waiver of premium will be effective the first of the month following your disability date.

Beneficiaries

You should name a primary and secondary (contingent) beneficiary in the Benefit Enrollment System for your Basic and Additional Life insurance benefits when you become insured.

You may allocate benefits by percentage only using a whole percentage. Primary beneficiary designations must equal 100%. Secondary beneficiary designations must also equal 100%.

You may change your beneficiary at any time. The new beneficiary designation will be effective as of the date you submit an electronic designation during Open Enrollment or make a beneficiary change online through the Benefit Enrollment system.

Short-Term Disability Plan

Administered by Sedgwick CMS

The Short-term Disability Plan (STD) replaces a portion of your monthly salary while you are disabled. There is a 3-week waiting period from the onset of your disability during which time you are required to use your sick leave. If you do not have enough sick leave, you must use vacation time during the waiting period. If you have more than 3 weeks sick leave, you must use all of it before benefits begin. The maximum payment STD period is 23 weeks (26 week benefit - 3 week waiting period = 23 week payment period). Any sick leave in excess of the 3-week waiting period reduces the 23-week payment period.

What benefit coverage amount can you elect?

You elect the benefit coverage amount when you enroll for STD coverage. You may elect 40%, 50%, 60% or 70% of your monthly base salary. The maximum benefit is $1,000 per week.

Note: If your weekly disability payment would be at the $1,000 per week maximum, you may be enrolling in a coverage level with a higher premium rate multiplier than necessary. Refer to the STD calculator on the EB Home page to determine the coverage level that charges the lowest premium and will yield the $1,000 per week maximum.

You may only increase or decrease your coverage during Open Enrollment. No changes will be allowed during the plan year (July 1 through June 30) except when ineligible for benefits (for example, you lose your active employee status due to a reduction in force or when called to active military duty).

This plan contains a pre-existing condition if you have a condition related to your disability for which you received treatment 90 days before your coverage became effective. In this case, benefits will not be payable for that condition until you have been treatment free for 3 months or covered by the plan for 12 months.

Coverage level changes made during Open Enrollment that result in an increase in coverage are subject to the pre-existing condition. For example, if you previously elected 50% benefit coverage and during an Open Enrollment period you changed your election to the 70% benefit coverage, the difference between the 50% and the 70% benefit is subject to pre-existing condition payment criteria. If you become disabled due to a pre-existing condition, your payment would be based on the 50% benefit coverage level until covered by the increased coverage for 12 months..

If your claim is related to a mental health diagnosis, Sedgwick CMS will work with Magellan Health Services to ensure that you receive a disability assessment and care by a licensed mental health professional and that you are assigned a care coordinator who will regularly work with you, Sedgwick CMS and your mental health provider on your treatment plan and your return-to-work goals.

The STD benefit includes a return-to-work incentive designed to lessen the financial hardship that your disability caused by allowing you to return to work on a part-time basis within your restrictions and limitations. Your STD benefit continues to be paid, within certain limits, in addition to your part-time

earnings. Refer to the STD Plan Description for an example of this calculation.

How is your benefit payment calculated?

To calculate the amount of your weekly benefit, multiply your base weekly earnings by the percentage of the benefit coverage amount you elected and deduct any other income you are receiving that offsets your benefit. Premiums for your health benefits will also be deducted from your weekly STD payment. Benefits payable for less than one weekly period will be pro-rated at the rate of one-seventh of the STD benefit amount for each day of disability.

Coverage	Multiplier
40%	0.3784%
50%	0.5536%
60%	0.8490%
70%	1.32%

Annual Base Salary: $25,000	40% Option	50% Option	60% Option	70% Option
Multiplier	0.003784	0.005536	0.008490	0.0132
Per Pay Period Multiplier *(Multiplier x (26/24))*	0.0041	0.006	0.0092	0.0143
Annual Premium	$94.60	$138.40	$212.25	$330.00
Deductions Per Year	24	24	24	24
Per Pay Period Premium *(Per Pay Period Salary x Per Pay Period Multiplier)*	$3.94	$5.77	$8.84	$13.75

Refer to the Short-Term Disability Plan Description on the EB Home page for further details or Sedgwick CMS (refer to the "**Who to Contact**" section) to file a claim for this benefit.

Flexible Spending Accounts

Administered by ADP

Maricopa County offers two flexible spending accounts (FSA) that allow you to pay for health care (General Purpose and Limited Use) and/or day care expenses on a tax-free basis for your dependents that you claim on your Federal tax return. When you elect to participate in an FSA, your gross income is reduced because your FSA contributions are not subject to Medicare, OASDI, federal or state income taxes. Once you enroll in an FSA, you must re-enroll annually during each Open Enrollment to renew your spending account(s).

Tip: If purchasing maintenance medication in a three-month supply (as required under the WHI pharmacy plans) is financially problematic, consider enrolling in either the Choice Fund medical plan that uses the CIGNA pharmacy plan that does not require you to purchase maintenance medication in three-month quantities, or the Health Care FSA. Additionally, all of the medical plans have deductibles, so it can be beneficial for you to consider opening a Health Care FSA since your entire annual plan year contribution is available immediately before you have made your full annual contribution. This allows you to use the debit card instead of your own cash.

When you enroll in the FSA, you will be asked to enter the annual amount of your contribution for the current plan year in the online Benefit Enrollment system. The system automatically divides the annual amount by the number of pay periods remaining in the plan year to determine the per pay period deduction. Deductions are taken 26 times during the plan year. Money that is contributed to an FSA will be forfeited per Proposed IRS Regulation § 1.125-5(c) (1), if not used and/or claimed according to the information and dates below. Forfeited funds revert to the Benefits Trust Fund and are used to offset administrative expenses associated with this Plan.

Incurred Expenses

For active employees, eligible health and dependent care expenses must be incurred during the plan year (July 1 through June 30). For Health Care FSA expenses, there is a 2 ½ month grace period (the following July 1 through September 15) in which expenses can be incurred in order to use any remaining contributions from the prior plan year. If you are currently enrolled in a General Purpose Health FSA with a grace period, and you enrolled in the Choice Fund medical plan for the next plan year and subsequently open a Health Savings Account, then you must incur expenses so that the balance in the General Purpose Health FSA is zero at the end of the current plan year.

For terminated (voluntary, involuntary or retired) employees, health and dependent care expenses must be incurred by the benefit termination date. There is no grace period for terminated employees.

Claims Filing Deadline

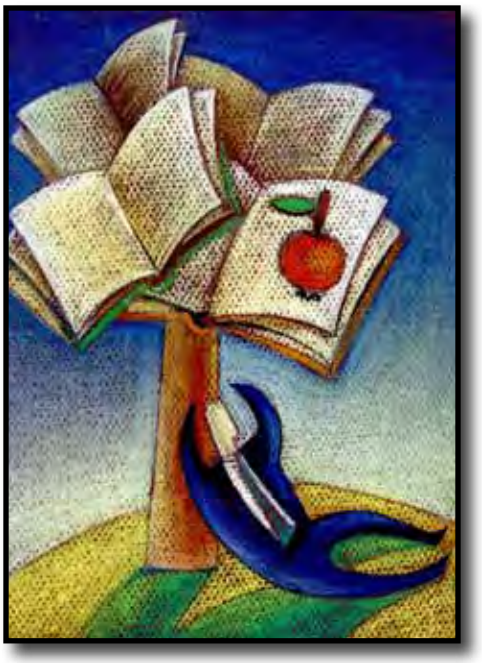
For active employees, claims for reimbursement for the Health Care FSA must be submitted by the following November 30th. For terminated employees, claims must be submitted within 60 days of your benefit termination date.

For active employees, claims for reimbursement for the Dependent Care FSA must be submitted by the following August 31st. For terminated employees, claims must be submitted within 60 days of your benefit termination date.

Debit Card and Paper Claims

Most Health Care FSA claims can be filed by using the ADP-provided debit card during the plan year. The debit card can also be used to file claims during the grace period for reimbursement of unused funds from the prior plan year, if you have re-enrolled in the FSA for the new plan year.

The debit card is provided as a payment convenience so that you can immediately access your full annual Health Care FSA contribution in advance of payroll deductions being taken for your full annual contribution in most cases. There are various regulations that control when the debit card transaction can be accepted with no follow-up documentation. Generally, pharmacy copays and co-insurance (except Mail Service claims) and physician office copays and co-insurance do not require you to submit documentation. Follow-up claim documentation will be required for some charges (for example for eye glasses) so be sure to keep your receipts and Explanation of Benefit statements. You will be notified by ADP if you need to send in receipts to substantiate your debit card transaction.



Paper claims may also be filed by completing the claim form located on the ADP Flexdirect Web site.

General Purpose Health Care FSA

You can enroll in the Health Care FSA (unless you enrolled in the Choice Fund medical plan) to pay for eligible health care expenses that are not covered by your insurance (or another Health Savings Account) such as office visit or prescription copays. Until January 1, 2011 certain over-the-counter products purchased to treat an existing or imminent medical condition may qualify as a covered medical expense. These over-the-counter items include allergy medication, smoking cessation products, aspirin, and cold medication. Eligible expenses are defined by the Internal Revenue Service and can be found in IRS Publication 502.

You can set aside up to $5,200 as your plan year maximum contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of $26 is required.

Limited Use Health Care FSA

If you enrolled in the CIGNA Choice Fund medical plan, you can still take advantage of an FSA. However, you and your covered dependents can only enroll in the Limited Use plan. This plan allows you to be reimbursed for dental and vision care services (as defined by the IRS) but not medical expenses.

You can set aside up to $5,200 as your plan year maximum contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of $26 is required.

Dependent Day Care FSA

Dependent Care Flexible Spending Accounts allow you to use pre-tax money to pay for dependent daycare for your dependents under age 13 or for your spouse or dependent who is physically or mentally incapable of self-care so that you and your spouse are able to work. Refer to IRS Publication 503 for more information.

You can set aside up to $5,000 as your plan year contribution. Deductions are taken 26 times per plan year. A minimum plan annual contribution of $26 is required.

Since your benefit plan year is based on a fiscal year, you will be responsible for controlling your IRS mandated calendar year maximum of $5,000 for the Dependent Care FSA.

Deferred Compensation

Administered by Nationwide Retirement Solutions

To enhance your future, Maricopa County offers you a deferred compensation plan. Your pension plan through ASRS or PSPRS was not designed to provide your entire retirement income, which is why participating in a deferred compensation program is an essential step to achieving financial independence upon retirement. A deferred compensation program allows you to contribute money, before it is taxed, to an account. When you withdraw the monies from your deferred compensation account, typically during retirement, you will have to pay the applicable taxes. However, tax is paid only on the amount you withdraw in a given year. Meanwhile, the rest of your investment has the opportunity to continue to grow tax deferred.

Once you enroll, contributions are deducted from your paycheck. You can make changes to the amount of your contribution at any time that your personal situation and needs change. The minimum contribution is $10 per pay period. The maximum contribution is 100% of includible compensation, up to $16,500 for calendar year 2010 if you are under age 50. If you are 50 or older, the catch-up provision allows you to contribute an additional $5,500 in 2010. If you are within three years of retirement, you may qualify to contribute more if you have past dollars to "catch up". For this pre-retirement window only, the maximum amount deferrable is the lesser of twice the normal deferral limit ($33,000) or 100% of includible compensation.

You have more than 35 investment choices as well as a Personal Choice Retirement Account through Schwab if you have at least $5,000 on account. As an added bonus, your money is available to you upon separation from County service with no early withdrawal penalty. Funds are also available for withdrawal for a financial hardship as defined by the IRS or through the loan provision where you can borrow up to 50% of the value of your account with a minimum of $1,000.

To request a consultation with a retirement specialist, contact Nationwide Retirement Solutions or visit their Web site. Refer to the "**Who to Contact**" section.

MetLaw® Group Legal Services

Administered by MetLife through Hyatt Legal Plans

Finding an affordably priced lawyer to represent you when you have trouble with creditors, buy or sell your home, or even prepare your will can be a challenge. Now there's a simple, affordable solution. MetLaw is a legal services plan that provides legal representation for you, your spouse and dependents at an affordable price.

Now you have a resource at your fingertips for important, everyday legal services. What's more, you'll also have someone to turn to for unexpected legal matters. With MetLaw, you can receive legal advice and fully covered legal service for a wide range of personal legal matters, including:

- Adoption & Legitimization
- Court Appearances
- Document Review and Preparation
- Debt Collection Defense
- Elder Law Matters
- Family Matters
- Personal Property Protection
- Real Estate Matters
- Security Deposit Assistance
- Traffic Ticket Defense (except DUI/DWI)
- Wills

Services are provided from a network of experienced attorneys either on the phone or in person. When you use a Plan Attorney, there are no deductibles, copays, waiting periods, claim forms or limits on usage. You also have the flexibility to use a non-Plan Attorney and get reimbursed for covered services according to a set fee schedule.

The premium for this plan is $7.87 per pay period, 24 pay periods per year.

For more information contact Hyatt Legal Plans or visit their Web site. Refer to the "**Who to Contact**" section.

Auto, Home and Renters Insurance

Administered by Liberty Mutual

As a Maricopa County employee, you qualify for a special group discount* on your auto, home and renters insurance through Group Savings Plus® from Liberty Mutual. With Group Savings Plus, you can enjoy the ease and convenience of paying your premiums through payroll or checking account deductions, with no down payment or finance charges. You also will enjoy fast, easy, round-the-clock claims service and a variety of discounts for multi-car, multi-policy, safe-driver, passive restraints and anti-theft devices.*

See for yourself how much money you could save with Liberty Mutual compared to your current insurance carrier. For a free, no-obligation quote, contact Liberty Mutual. Refer to the "**Who to Contact**" section.

*Discounts and credits are available where state laws and regulations allow and may vary by state. Certain discounts apply to specific coverage only. To the extent permitted by law, applicants are individually underwritten; not all applicants may qualify. Coverage is provided and underwritten by Liberty Mutual Insurance Company and its affiliates, 175 Berkeley Street, Boston, MA.

Enrollment Checklist

☐ 1. Complete the Worksheet that was mailed to you by noting your benefit enrollment elections. This will help you to complete your online enrollment quickly.

- Please note that after 15 minutes of inactivity, you will be logged out of the online Benefit Enrollment System. Your changes will be saved as long as you go back and finish your elections by 8 PM MST on the same day.

☐ 2. If not previously registered with the ADP Self-Service Portal, type **https://portal.adp.com** in the Internet Explorer browser address bar. Click on the link "First Time Users Register Here". Then click on the "Register Now" button and follow the prompts.

- The registration pass code for Maricopa County is MCAZ-PRISM09 (this pass code is not case sensitive and contains a zero, not the letter O).
- During the registration process you will set your own password and answer security questions. The answers to the security questions are case sensitive so be sure to write down your password and answers to the security questions for later reference. Store them in a secure location.

☐ 3. Log on to the portal before the end of the enrollment period specified on your Worksheet.

☐ 4. Click on the "Benefits" tab at the top of the portal page and then click on "Welcome" on the drop-down list.

☐ 5. On the next page, click on the "Benefit Enrollment System" link.

☐ 6. Read the "Welcome" page and press "Continue".

☐ 7. Read the instructions for completing each page, located in the left-hand column.

☐ 8. At the Main Menu, click on the Newly Eligible or other appropriate link.

☐ 9. Review your Personal Information. If incorrect, contact Employee Records at: (602) 506-3519

☐ 10. Add any of your eligible dependents that you will be enrolling. Dependents must be added in order to be enrolled in a benefit or for spouse or child life insurance coverage.

☐ 11. Update your beneficiary information.

☐ 12. Update your Benefit elections. **Make sure that dependents are enrolled in each benefit by checking the box next to their names.**

☐ **13. Click on the submit button** to save your elections.

☐ 14. Enter your email address if you would like an email acknowledgement that you completed enrollment or click Cancel.

☐ 15. Print your Confirmation page for your records.

☐ 16. A Confirmation Statement will be mailed to your home address within the next 10 days.

☐ 17. Compare the Confirmation page you printed in step 16 above with the Confirmation Statement you receive in the mail.

☐ 18. If the information on the Confirmation Statement does not match your printed Confirmation page, contact the EB Division within 10 business days at 602-506-1010, press 2 and then 2 again.

For an illustrated step by step instruction go to:

http://www.maricopa.gov/benefits/pdf/2010/systeminstructions.pdf

Enrollment Worksheet Sample

Maricopa County Employee Benefits
301 S 4th Ave, Suite B100
Phoenix, AZ 85003

2010-2011 Benefits Enrollment Worksheet

ENROLLMENT DEADLINE
07/28/2010

MCYWO
JST5 0001

John Smith
1 North Central Avenue
Phoenix, AZ 85003

Printed: 07/12/2010
Event: New Hire
Employee ID: 811123321

Enrollment Instructions:

1. Review this Worksheet. You will be enrolled in the benefit coverage marked with a check (✓) unless you make a change.
2. Complete this Worksheet before you go online to make benefit changes.
3. Use the boxes on the left-hand side of the Worksheet to indicate the option code and cost for each benefit you select.
4. Enroll online at https://portal.adp.com by the enrollment deadline shown above.
5. If you do not have access to a computer, check with your department HR Liaison for computer resources that will be available for your use.
6. Paper enrollment or late enrollment will not be accepted. Contact 602-506-1010 if you have enrollment questions.
7. You must register at https://portal.adp.com. Your registration pass code is MCAZ-PRISM09.
8. For information regarding the benefits offered, please visit www.maricopa.gov/benefits or the internal Intranet at http://ebc.maricopa.gov/ehi.
9. Review the *Know Your Benefits* booklet for the current plan year or the *What's New* booklet during the open enrollment period.
10. This worksheet represents all of your available options. Based on your event you may not be able to make changes to all options.

Dependent Information

You are responsible for adding only eligible dependents and updating any incorrect or incomplete dependent information. The following list displays all individuals who are currently enrolled in benefits as your dependent.

No.	Name	Relationship*	Birth Date	Sex	Student	Disabled	Medical	Dental	Vision
0	John Smith	EE	08/13/1981	M			Y		Y

*Relationship codes are:
EE = Employee, SP = Spouse, CH = Child, SC = Step-Child, LG = Legal Guardian, CO = Court-order, BN = Beneficiary

Medical

Your Choice
Option Code
Cost

Option Code	Option Name	Coverage Category/Cost Per Pay Period: Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
001	CIGNA Medical Group High *	$37.18	$56.39	$44.51	$75.58
002	CIGNA Medical Group Low *	$34.66	$48.05	$39.88	$60.74
003	Open Access Plus In-Network	$46.10	$104.57	$83.13	$140.62
004	Open Access Plus High	$46.73	$104.04	$83.89	$141.52
005	Open Access Plus Low	$34.62	$47.80	$39.86	$60.98
✓006	**Choice Fund - HSA**	**✓$30.00**	$30.00	$30.00	$30.00
000	Waived				

* You are required to provide the code for the Primary Care Provider at the time you enroll. Contact the plan to obtain the PCP code.

Biometric Screening Incentive

Employees (not including dependents) enrolled in a County-sponsored medical plan who participate in the annual Biometric Screening will save up to $120 per plan year on their medical insurance premium. The biometric screening provided by CIGNA Onsite Health consists of completing a brief personal health history as well as having your measurements taken for height, weight, blood pressure, waist circumference, body fat composition, cholesterol, and glucose levels.

Health Assessment Incentive

Employees (not including dependents) enrolled in a County-sponsored medical plan who participate in the annual Health Assessment will save up to $120 per plan year on their medical insurance premium. The Health Assessment is available online through www.mycigna.com and consists of a series of questions about your health and lifestyle. Your confidential responses are then assessed by the online tool to determine your health risks.

Enroll online at https://portal.adp.com by 07/28/2010

JST5 0001 0104

2010-2011 Benefits Enrollment Worksheet

Non-Tobacco User Incentive

When employees and all of their dependents enrolled in a County-sponsored medical plan do not use tobacco products (occasionally or regularly), they will save up to $480 per plan year on their medical insurance premium. Tobacco use includes cigarettes, cigars, pipes, snuff, chewing tobacco and any other product containing tobacco during the last six consecutive months.

Health Savings Account

When you enroll in the Choice Fund Health Savings Account medical plan, you may contribute to your Health Savings Account on an annual basis. You can contribute up to $3,050 (individual) or $6,150 (family) to your account for calendar year 2010 minus the amount contributed by Maricopa County. If you are 55 or above, you can contribute an additional $1,000. Unused balances remain in your account.

Pharmacy

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
001	Co-insurance Prescription Plan	$5.57	$11.03	$8.29	$16.56
002	Consumer Choice Prescription Plan	$0.00	$0.00	$0.00	$0.00
✓003	**Choice Fund HSA Prescription Plan**	**✓$0.00**	$0.00	$0.00	$0.00
000	Waived Prescription				

Vision

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

If you enroll in any County-sponsored medical plan, you must enroll in the vision plan (EyeMed with Med election). The County also offers this plan as a separate (stand-alone) vision plan for employees who choose to waive their medical benefits and wish to enroll in the vision plan (EyeMed no Med election). However, you may not enroll your dependents in a vision plan if they are not enrolled in your medical plan.

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
✓001	**EyeMed (with Med election)**	**✓$0.00**	$0.00	$0.00	$0.00
002	EyeMed (no Med election)	$5.36	$10.12	$10.60	$15.56
000	Waived Vision				

Behavioral Health Coverage

The behavioral health coverage is provided as part of your enrollment in a County-sponsored medical plan and is provided to you at minimal cost. Enrollment is mandatory.

Dental

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Option Code	Option Name	Employee Only	Employee plus Spouse	Employee plus Child(ren)	Employee plus Family
001	Employers Dental Services *	$2.16	$4.10	$5.38	$6.18
002	CIGNA Dental	$7.23	$15.95	$17.25	$22.18
003	Delta Dental	$13.71	$30.25	$32.71	$42.06
✓000	**Waived Dental**				

* You are required to provide the code for the Primary Care Provider at the time you enroll. Contact the plan to obtain the PCP code.

2010-2011 Benefits Enrollment Worksheet

Additional Life Insurance

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Basic Life Insurance of 1X Annual Base Salary is provided to you at no cost. You may elect additional coverage from the following options:

Option Code	Coverage Level	Non Tobacco User	Tobacco User
001	1X Annual Base Salary	$1.02	$1.32
002	2X Annual Base Salary	$2.05	$2.64
003	3X Annual Base Salary	$3.07	$3.96
004	4X Annual Base Salary	$4.09	$5.28
005	5X Annual Base Salary	$5.12	$6.60
✓000	**Waived Additional Life**	$0.00	$0.00

Additional Accidental Death and Dismemberment

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Basic Accidental Death and Dismemberment (AD&D) Insurance of 1X Annual Base Salary is provided to you at no cost. You may elect additional coverage from the following options:

Option Code	Coverage Level	Employee Only	Employee Plus Family
001	1X Annual Base Salary	$0.33	$0.58
002	2X Annual Base Salary	$0.66	$1.16
003	3X Annual Base Salary	$0.99	$1.73
004	4X Annual Base Salary	$1.32	$2.31
005	5X Annual Base Salary	$1.65	$2.89
✓000	**Waived Additional AD&D**	$0.00	$0.00

Spouse Life Insurance

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

If there is not a spouse listed on file, the rates on this worksheet will be based on the employee's age. Once your spouse is on file the rates will be adjusted based on the spouse's age. The rates on the confirmation statement will be the adjusted rate.

Option Code	Coverage Level	Cost Per Pay Period	Option Code	Coverage Level	Cost Per Pay Period
001	$10,000	$0.44	007	$70,000*	$3.08
002	$20,000	$0.88	008	$80,000*	$3.52
003	$30,000	$1.32	009	$90,000*	$3.96
004	$40,000	$1.76	010	$100,000*	$4.40
005	$50,000	$2.20	✓000	**Waived Spouse Life**	
006	$60,000*	$2.64			

* You must complete an Evidence of Insurability (EOI) form if you choose this Coverage Level. Please review enrollment information at https://portal.adp.com for details.

Child Life Insurance

Coverage Category/Cost Per Pay Period

Your Choice
Option Code
Cost

Option Code	Coverage Option	Cost Per Pay Period
001	$5,000	$0.25
002	$10,000	$0.50
003	$15,000*	$0.75
004	$20,000*	$1.00
✓ 000	**Waived Child Life**	

* You must complete an Evidence of Insurability (EOI) form if you choose this Coverage Level. Please review enrollment information at https://portal.adp.com for details.

Enroll online at https://portal.adp.com by 07/28/2010

JST5 0001 0304

2010-2011 Benefits Enrollment Worksheet

Short Term Disability

Coverage Category/Cost Per Pay Period

Your Choice

Option Code

Cost

Option Code	Coverage Level	Cost Per Pay Period	Option Code	Coverage Level	Cost Per Pay Period
001	40% STD Coverage	$5.10	004	70% STD Coverage	$17.78
002	50% STD Coverage	$7.46	✓**000**	**Waived STD Coverage**	
003	60% STD Coverage	$11.44			

Health Care Flexible Spending Account

Annual Goal

(Pre-Tax Contribution)

When you enroll in the Health Care Spending Account, you may contribute from $26.00 to $5,200.00 for the plan year. The amount you elect will be divided by the number of pay periods in the plan year and taken from each paycheck.

You will default to no contribution if you do not make an election.

Dependent Care Flexible Spending Account

Annual Goal

(Pre-Tax Contribution)

When you enroll in the Dependent Care Spending Account, you may contribute from $26.00 to $5,000.00 for the plan year. The amount you elect will be divided by the number of pay periods in the plan year and taken from each paycheck.

You will default to no contribution if you do not make an election.

Employee Assistance Program

The Employee Assistance Program is provided to you at no cost.

Group Legal Services

Coverage Category/Cost Per Pay Period

Your Choice

Option Code

Cost

	Option Code	Coverage Option	Cost Per Pay Period
	001	METLAW Group Legal Services	$7.87
✓	**000**	**Waived Group Legal**	

ID Cards

- CIGNA medical plan ID cards are issued to all new enrollees. CIGNA issues an individual ID card for each enrollee (insured employee and dependent). Each person is identified with an individual person code. Temporary ID cards are available on **www.mycigna.com**.

  The CIGNA medical ID card for the Choice Fund medical plan is used to receive medical, pharmacy and behavioral health services. The CIGNA ID cards for the other medical plans (CMG High, CMG Low, OAPIN, OAP High and OAP Low) are only used to receive medical services since pharmacy coverage is available through WHI and behavioral health coverage is available through Magellan.

- Walgreens Health Initiatives (WHI) pharmacy plan ID cards are issued to all new enrollees for the Co-insurance and Consumer Choice plans. There is one ID card per family that lists the insured employee and all dependents. Each person is identified with an individual person code. Temporary ID cards are available on **www.mywhi.com**.

- There are no personalized ID cards for the CIGNA Dental plan. To print an ID card, go to the EB Home page, click on the Dental tab, then under the CIGNA Dental heading, click on the link CIGNA Dental ID Card.

- Delta Dental plan ID cards are issued to all new enrollees. ID cards are located on the back cover of the Delta Dental Summary of Benefits booklet mailed to your home address shortly after enrollment.

- Employers Dental Services ID cards are issued to all new enrollees. Two ID cards are issued in the employee's name and can be used by all enrolled dependents. Members are not required to show an ID card when seeking services because the EDS dentists receive a roster on the 1st and 15th of each month and all members assigned to that dentist are listed on the roster.

- EyeMed Vision issues ID cards to all new enrollees in the name of the insured. Additional cards may be printed from their Web site at **www.eyemedvisioncare.com**.

- Health Care Flexible Spending Account (FSA) debit cards are issued to all new enrollees. If you need additional debit cards for family members, you must complete a debit card request form available at **www.flexdirect.adp.com**.

  Employees re-enrolling in the Health Care FSA during Open Enrollment are not issued new debit cards. Their debit card is automatically reloaded with their new annual election amount at the beginning of the next plan year.

- There are no personalized ID cards for the Employee Assistance Program (EAP), administered by Magellan Health Services.

  Wallet cards for the Employee Assistance Program (EAP) are located on the EAP page. Go to the EB Home page, click on the Magellan tab, then under the EAP heading click on the link to the EAP page. Or us the address below:
  http://ebc.maricopa.gov/ehi/pdf/2009/Magellan/magellan_brochure.pdf.

  There are no personalized ID cards for the behavioral health/substance abuse benefit, administered by Magellan Health Services. However, the phone number on the EAP wallet card described above should be used to access these benefits.

- There are no personalized ID cards for the MetLaw Group Legal plan. Wallet cards for this plan are located on MetLaw brochure. The brochure is available on the EB Home page by clicking on the Other tab, then scrolling down to the Hyatt Legal Plans section and clicking on the MetLaw brochure.

- There are no ID cards for Short-term Disability Benefits.

FY 2010-2011 Payroll Schedule
Used For Benefit Premium Calculations, Coverage Effective Dates & Coverage End Dates

	Beginning	Ending	Pay Day
1	June 14, 2010	June 27, 2010	July 2, 2010
2	June 28, 2010	July 11, 2010	July 16, 2010
3	July 12, 2010	July 25, 2010	July 30, 2010
4	July 26, 2010	August 8, 2010	August 13, 2010
5	August 9, 2010	August 22, 2010	August 27, 2010
6	August 23, 2010	September 5, 2010	September 10, 2010
7	September 6, 2010	September 19, 2010	September 24, 2010
8	September 20, 2010	October 3, 2010	October 8, 2010
9	October 4, 2010	October 17, 2010	October 22, 2010
10	October 18, 2010	October 31, 2010	November 5, 2010
11	November 1, 2010	November 14, 2010	November 19, 2010
12	November 15, 2010	November 28, 2010	December 3, 2010
13	November 29, 2010	December 12, 2010	December 17, 2010
14	December 13, 2010	December 26, 2010	December 30, 2010
15	December 27, 2010	January 9, 2011	January 14, 2011
16	January 10, 2011	January 23, 2011	January 28, 2011
17	January 24, 2011	February 6, 2011	February 11, 2011
18	February 7, 2011	February 20, 2011	February 25, 2011
19	February 21, 2011	March 6, 2011	March 11, 2011
20	March 7, 2011	March 20, 2011	March 25, 2011
21	March 21, 2011	April 3, 2011	April 8, 2011
22	April 4, 2011	April 17, 2011	April 22, 2011
23	April 18, 2011	May 1, 2011	May 6, 2011
24	May 2, 2011	May 15, 2011	May 20, 2011
25	May 16, 2011	May 29, 2011	June 3, 2011
26	May 30, 2011	June 12, 2011	June 17, 2011

Holiday Schedule

	2010	2011
New Year's Day	Friday, January 1	Friday, December 31
Martin Luther King Jr./Civil Rights Day	Monday, January 18	Monday, January 17
President's Day	Monday, February 15	Monday, February 21
Memorial Day	Monday, May 31	Monday, May 30
Independence Day	Monday, July 5	Monday, July 5
Labor Day	Monday, September 6	Monday, September 5
Columbus Day	Monday, October 11	Monday, October 10
Veteran's Day	Thursday, November 11	Friday, November 11
Thanksgiving Day	Thursday, November 25	Thursday, November 24
Christmas Day	Friday, December 24	Monday, December 26

Notifications

HIPAA Privacy Notice

In accordance with the privacy standards contained in the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Maricopa County, in its role as the administrator and/or sponsor of the Maricopa County Health Insurance Program, or in its role as the health plan makes available a notice setting forth its privacy practices through the EBC/Intranet **http://ebc.maricopa.gov/ehi** home page. This notice describes the potential uses and disclosures of Protected Health Information (PHI), the individual's rights and the plan's legal duties with respect to PHI. The privacy notice may be updated occasionally and such updates will be communicated through **e*Nouncements**, accessible through the EBC.

Maricopa County's Group Health Plan
Notice of Privacy Practices

The Health Insurance Portability and Accountability Act, otherwise known as HIPAA, requires Maricopa County to protect the privacy of your personal health information, and to provide you with this notice. HIPAA is a federal law that was effective April 14, 2003. The reason the law requires Maricopa County to provide you with this notice is because certain benefit programs administered through the Employee Benefits Division are considered to be a Group Health Plan that is regulated by this law. This notice explains how your personal health information may be used, and what kind of rights you have under this law.

THIS INFORMATION DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Maricopa County offers a Group Health Plan (the "Plan"), which is a type of Health Plan, for eligible regular employees, certain contract employees, retirees, and COBRA participants.

The Plan is required by law to take reasonable steps to ensure the privacy of your personally identifiable health information and to inform you about:

- the Plan's uses and disclosures of your Protected Health Information (PHI);
- your rights with respect to your PHI;
- the Plan's duties with respect to your PHI;
- your right to file a complaint with the Plan and to the Secretary of the U.S. Department of Health and Human Services; and
- the person or office to contact for further information about the Plan's privacy practices.

The term "Protected Health Information" ("PHI") includes all individually identifiable health information transmitted or maintained by the Plan whether oral, written, or electronic.

SECTION 1. NOTICE OF PHI USES AND DISCLOSURES

Upon your request, the Plan is required to give you access to certain PHI in order to inspect and copy it. Use and disclosure of your PHI may be required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine the Plan's compliance with the privacy regulations.

Uses and Disclosures to Carry Out Treatment, Payment, and Health Care Operations

The entities that provide coverage under your medical, prescription, behavioral health and substance abuse, dental, vision, flexible spending accounts, and COBRA, may share your PHI for treatment purposes, to get paid for treatment, or to conduct health care operations. Many of these entities may provide you with their own Notice of Privacy Practices. Refer to Table A for a list of the current entities that provide the above coverage.

The Plan and/or its business associates may use your PHI, without your consent, authorization, or opportunity to agree or object, to carry out treatment, payment, and health care operations. For each business associate, the Plan has a written contract that contains terms to protect the privacy of your PHI.

The Plan may also share your information or allow the sharing of your PHI with Maricopa County as the Plan Sponsor for plan administration functions. The Plan Sponsor has amended its plan documents to protect your PHI as required by federal law.

Treatment is defined as the provision, coordination, or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. In addition, providers may share information with each other. The Plan does not use PHI for treatment purposes.

Payment includes, but is not limited to, actions to make coverage determinations and payment (including billing, premium payment, recovery and collections, claims management, subrogation, reimbursements of overpayments, coordination of benefits, reviews for medical necessity and appropriateness of care and utilization review and pre-authorizations). For example, the Plan may tell a doctor (provider) whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include, but are not limited to, quality assessment and improvement, reviewing competence or qualifications of health care professionals, underwriting, premium rating, and other insurance activities relating to creating or renewing insurance contracts. It also includes disease management, case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to determine compliance with physician-issued prescriptions, refer you to a disease or case management program, project future benefit costs or audit the accuracy of its claims processing functions.

Uses and Disclosures That Require Your Written Authorization

Your written authorization will be obtained before the Plan will use or disclose PHI for employer-related activities that include, but are not limited to, ombudsman activities which includes resolving your claims issue, fitness for duty examinations, short- term disability claims, return-to-work programs, employee assistance plan, ergonomics evaluations, wellness programs, workers' compensations claims, and care received at an on-site medical clinic. You may revoke your authorization in writing, at anytime, to stop any future uses or disclosures.

Certain types of PHI, including PHI regarding communicable disease and HIV/AIDS, drug and alcohol abuse treatment, and evaluation and treatment for serious mental illness, may have additional protection under state or federal law. Your written authorization is required in order to release this type of information.

Uses and Disclosures That Require You Be Given an Opportunity to Agree or Disagree Prior To the Use or Release

Disclosure of your PHI to family members, other relatives, and your close friends is allowed if:

- the information is directly relevant to the family or friend's involvement with your care or payment for that care, and
- you either have agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures for Which Consent, Authorization, or Opportunity to Object Is Not Required

Use and disclosure of your PHI is allowed without your consent, authorization, or request under the following circumstances:

1. When required by law.

2. When authorized by law regarding when you have been exposed to a communicable disease or are at risk of spreading a disease or condition.

3. When authorized by law to report information about abuse, neglect, or domestic violence to public authorities if there exists a reasonable belief that you may be a victim of abuse, neglect, or domestic violence. In such case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice could cause a risk or serious harm. For purposes of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's PHI.

4. The Plan may disclose your PHI to a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations, inspections, and licensure or for disciplinary actions (for example, to investigate complaints against providers); and other activities necessary for appropriate oversight of government benefit programs (for example, to investigate health care fraud).

5. The Plan may disclose your PHI when required for judicial or administrative proceedings. For example, your PHI may be disclosed in response to a subpoena or discovery request provided certain conditions are met. One of those conditions is that satisfactory assurances must be given to the Plan that the requesting party has made a good faith attempt to provide written notice to you, and the notice provided sufficient information about the proceeding to permit you to raise an objection and no objections were raised or were resolved in favor of disclosure by the court or tribunal.

6. When required for law enforcement purposes (for example, to report certain types of wounds).

7. For law enforcement purposes, including for the purpose of identifying or locating a suspect, fugitive, material witness or missing person. Also, when disclosing information about an individual who is or is suspected to be a victim of a crime but only if the individual agrees to the disclosure or the covered entity is unable to obtain the individual's agreement because of emergency circumstances. Furthermore, the law enforcement official must represent that the information is not intended to be used against the individual, the immediate law enforcement activity would be materially and adversely affected by waiting to obtain the individual's agreement and disclosure is in the best interest of the individual as determined by the exercise of the Plan's best judgment.

8. When required to be given to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law. Also, disclosure is permitted to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent.

9. The Plan may use or disclose PHI for research, subject to conditions.

10. When consistent with applicable law and standards of ethical conduct if the Plan, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public and the disclosure is to a person reasonably able to prevent or lessen the threat, including the target of the threat.

11. When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.

Except as otherwise indicated in this notice, uses and disclosures will be made only with your written authorization subject to your right to revoke such authorization.

SECTION 2. RIGHTS OF INDIVIDUALS

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan will accommodate reasonable requests to receive communications of PHI by alternative means or at alternative locations. You or your personal representative will be required to complete a form to request restrictions on uses and disclosures of your PHI. Such requests should be made in writing to the **Employee Benefits Manager, 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003**.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a "designated record set," for as long as the Plan maintains the PHI. *"Protected Health Information"* (PHI) includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form. *"Designated Record Set"* includes the medical records and billing records about individuals maintained by or for a covered health care provider; enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used in whole or in part by or for the covered entity to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. You or your personal representative will be required to complete a form to request access to the PHI in your designated record set. Requests for access to PHI should be made in writing to the **Employee Benefits Manager, 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003**. If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise those review rights and a description of how you may complain to the Secretary of the U.S. Department of Health and Human Services.

Right to Amend PHI

If you believe your PHI is erroneous or incomplete, you have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You must make this request in writing and provide a reason to support your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI. Requests for amendment of PHI in a designated record set should be made in writing to the **Employee Benefits Manager, 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003**. You or your personal representative will be required to complete a form to request amendment of the PHI in your designated record set.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request, but not before April 14, 2003. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; (3) prior to the compliance date; or (4) based on your written authorization. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if the individual is given a written statement of the reasons for the delay and the date by which the accounting will be provided. If you request more than one accounting within a 12-month period, the Plan will charge a reasonable, cost-based fee for each subsequent accounting.

Notice of Breach

If the Plan or one of its business associates acquires, accesses, uses or discloses your PHI in a manner not permitted by HIPAA that compromises the security or privacy of your PHI (a "breach"), the Plan is required to notify you. The notification shall be in writing and may include: (a) a description of what happened, (b) the dates of the breach and its discovery, (c) a description of the type of information involved, (d) steps you should take to protect yourself from harm that may result from the breach, (e) a description of what the Plan or its business associate is doing to investigate the breach, mitigate harm and protect against further breaches, and (f) contact procedures for you to ask questions or obtain additional information about the breach.

The Right to Receive a Paper copy of This Notice upon Request

To obtain a paper copy of this Notice, contact the **Employee Benefits Manager in writing at 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003**.

SECTION 3. THE PLAN'S DUTIES

The Plan is required by law to maintain the privacy of PHI and to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices. This is effective beginning April 14, 2003 and the Plan is required to comply with the terms of this notice. However, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan

prior to that date. If a privacy practice is changed, a revised version of this notice will be provided to all participants for whom the Plan still maintains PHI. The notice will be distributed electronically via the Electronic Business Center (EBC) Intranet and on the Employee Benefits Home page. Any revised version of this notice will be distributed within 60 days of the effective date of any material change to the uses or disclosures, the individuals rights, the duties of the Plan or other privacy practices stated in this notice.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- disclosures to or requests by a health care provider for treatment;
- uses or disclosures made to the individual;
- disclosures made to the Secretary of the U.S. Department of Health and Human Services;
- uses or disclosures that are required by law; and
- uses or disclosures that are required for the Plan's compliance with legal regulations.

This notice does not apply to information that has been de-identified. De-identified information is information that does not identify an individual. With respect to information to which there is no reasonable basis to believe that the information can be used to identify an individual, such information is not individually identifiable health information.

In addition, the Plan may use or disclose "summary health information" to the plan sponsor or business associates for obtaining premium bids or modifying, amending or terminating the group health plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits under a group health plan; and from which identifying information has been deleted in accordance with HIPAA.

SECTION 4. YOUR RIGHT TO FILE A COMPLAINT WITH THE PLAN OR DEPARTMENT OF HEALTH AND HUMAN SERVICES, OFFICE FOR CIVIL RIGHTS

If you believe that your privacy rights have been violated, you may complain to the Plan by writing to the Employee Benefits Manager, 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003. You may file a written complaint, either on paper or electronically, by mail, fax, or e-mail with the Secretary of the Department of Health and Human Services. To obtain a copy of the complaint form or for more information about the Privacy Rule or how to file a complaint with Office for Civil Rights, contact any OCR office or go to www.hhs.gov/ocr/hipaa. Mailing address: Office for Civil Rights, U.S. Department of Health & Human Services, 50 United Nations Plaza – Room 322, San Francisco, CA 94102, Telephone (415) 437-8310, Fax (415) 437-8329, TDD (415) 437-8311. Visit the HHS OCR website at www.hhs.gov/ocr/privacy for more information. The Plan will not retaliate against you for filing a complaint.

SECTION 5. WHOM TO CONTACT AT THE PLAN FOR MORE INFORMATION

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following individual: Employee Benefits Manager, 301 S. 4th Avenue, Suite B100, Phoenix, AZ 85003, telephone number (602) 506-1010, or via electronic mail BenefitsService@mail.maricopa.gov.

SECTION 6. CONCLUSION

PHI use and disclosure by the Plan is regulated by a federal law known as HIPAA (the Health Insurance Portability and Accountability Act). You may find these rules at *45 Code of Federal Regulations Parts 160 and 164*. This notice attempts to summarize the regulations. The regulations will supersede any discrepancy between the information in this notice and the regulations.

TABLE A

Entity	Description of Coverage	Entity	Description of Coverage
CIGNA HealthCare of AZ	Medical and Pharmacy	Magellan Health Services	Behavioral Health & Substance Abuse
Walgreens	Pharmacy	EyeMed Vision Care	Vision
CIGNA Dental	Dental	ADP	Flexible Spending Accounts
Delta Dental	Dental	ADP	COBRA
Employers Dental Services (EDS)	Dental		

EMPLOYEE ACKNOWLEDGEMENT

I hereby acknowledge receipt of this **Notice of Privacy Practices** and understand that is my responsibility to read the information contained herein.

Employee Name (printed) _____ Employee Signature _____ Date _____

Return your signed copy of this form to your Department HR Liaison

COBRA Initial Notification

This notice on possible future group health insurance continuation coverage rights applies individually to the following plan participants: **Employee, Spouse, and each covered dependent**.

It is being provided to you at this time because you have recently become, or are about to become, covered under a Maricopa County sponsored health plan. It is important that all covered individuals take the time to read this notice carefully and be familiar with its contents. Should you add additional dependents in the future, notice to the covered employee and spouse at this time will be deemed notification to the newly covered dependent.

Plan Administrator:

Maricopa County Employee Benefits Division
301 S. 4th Ave., Suite B100
Phoenix, Arizona 85003
Telephone number 602-506-1010
Fax number: 602-506-2354
Email: **BenefitsService@mail.maricopa.gov**

COBRA continuation coverage for the Plan is managed by:

ADP, Inc.
Telephone number 1-800-770-7981
https://www.benedirect.adp.com

Under federal COBRA law, should you lose your group health insurance due to one of the below listed qualifying events, covered employees and covered family members (called qualified beneficiaries) will be offered the opportunity for a temporary extension of health coverage (called Continuation Coverage) at group rates which you will be required to pay. This notice is intended to inform all plan participants, in a summary fashion of your potential **future** options and obligations under the continuation coverage provisions of federal law. Should an actual qualifying event occur in the future, the plan administrator will send you additional information and the appropriate election notice at that time. **Please take special note, however, of your notification obligations and procedures which are highlighted in this notification!**

Qualifying Events for Covered Employee*

If you are the covered employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage **if** you lose your group health coverage because of a termination of your employment (for reasons other than gross misconduct on your part) or a reduction in your hours of employment.

Qualifying Events for Covered Spouse*

If you are the **covered** spouse of an employee, you will become a qualified beneficiary and have the right to elect this health plan continuation coverage for yourself **if** you lose group health coverage because of any of the following reasons:

1. A termination of your spouse's employment (for reasons other than gross misconduct) or reduction in your spouse's hours of employment;
2. The death of your spouse;
3. Divorce or, if applicable, a legal separation from your spouse; or
4. Your spouse becomes enrolled in Medicare (Part A, Part B, or both).

Qualifying Events for Covered Dependent Children*

If you are the **covered** dependent child of an employee, you will become a qualified beneficiary and have the right to elect continuation coverage for yourself **if** you lose group health coverage because of any of the following reasons:

1. A termination of the parent-employee's employment (for reasons other than gross misconduct) or reduction in the parent-employee's hours of employment;
2. The death of the parent-employee;
3. Parent's divorce or, if applicable, a legal separation;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both); or
5. You cease to be eligible for coverage as a "dependent child" under the terms of the health plan.

*Rights similar to those described above may apply to covered retirees, and their covered spouses, and dependents if Maricopa County commences a bankruptcy proceeding under title 11 of the United States code and these individuals lose coverage within one year of or one year after the bankruptcy filing.

Employee/Qualified Beneficiary 60 Day Notification Requirement

Under group health plan rules and COBRA law, the employee, spouse, or other covered family members have the responsibility to notify the Plan Administrator of a divorce, legal separation, or a child losing dependent status under the plan. Please read your summary plan description for specific information on when a dependent ceases to be a dependent under the terms of the plan. To protect your continuation coverage rights in these two situations, this notification must be made within 60 calendar days from whichever date is later, the date of the event or the date on which health plan coverage would be lost under the terms of the insurance contract because of the event. Procedures for making proper and timely notice are listed below.

1. Complete a Group Insurance Qualified Status Change form.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event.
4. Mail the notification form to the Plan Administrator and document your mailing.
5. Call the Plan Administrator within 10 calendar days to insure the notification form has been received.

If this notification is not completed according to the outlined procedures and within the required 60 day notification period, then rights to continuation coverage will be forfeited. In addition, keeping an individual covered by the health plan beyond what is allowed by the plan will be considered insurance fraud on the part of the employee.

If the qualifying event is a termination of employment, reduction in hours, death, enrollment in Medicare (Part A, Part B, or both), or for retiree coverage, a commencement of a bankruptcy proceeding, the employer will notify the Plan Administrator within 30 calendar days of the qualifying event.

Election Period and Coverage

Once the Plan Administrator learns a qualifying event has occurred, the Plan Administrator will notify qualified beneficiaries of their rights to elect continuation coverage. Each qualified beneficiary has independent election rights and will have 60 calendar days to elect continuation coverage. The 60 calendar day election window is measured from the later of the date health plan coverage is lost due to the event or from the date of notification. This is the maximum period allowed to elect continuation coverage as the plan does not provide an extension of the election period beyond what is required by law. For each qualified beneficiary who elects group health insurance continuation coverage, coverage will begin on the date that coverage under the plan would be lost because of the event. If a qualified beneficiary does not

elect continuation coverage within this election period, then rights to continue health insurance will end and he/she ceases to be a qualified beneficiary.

If a qualified beneficiary elects continuation coverage, he/she will be required to pay the entire cost for the health insurance, plus a 2% administration fee. Maricopa County is required to provide the qualified beneficiary with coverage that is identical to the coverage provided under the plan to similarly situated non-COBRA participants and/or covered dependents. Should coverage change or be modified for non-COBRA participants, then the change and/or modification will be made to your coverage as well.

Length of Continuation Coverage - 18 Months

If the event causing the loss of coverage is a termination of employment (other than for reasons of gross misconduct) or a reduction in work hours, then each qualified beneficiary will have the opportunity to continue coverage for 18 months from the date of the qualifying event. **Exception**: If you are participating in a health flexible spending account at the time of the qualifying event, you will only be allowed to continue the health flexible spending account until the end of the current plan year in which the qualifying event occurs.

Social Security Disability Extension - The 18 months of continuation coverage can be extended for an additional 11 months of coverage, to a maximum of 29 months, for all qualified beneficiaries if the Social Security Administration determines a qualified beneficiary was disabled according to Title II or XVI of the Social Security Act on the date of the qualifying event or at any time during the first 60 calendar days of continuation coverage. In the case of a newborn or adopted child that is added to a covered employee's continuation coverage, the first 60 calendar days of continuation coverage for the newborn or adopted child is measured from the date of the birth or the date of the adoption. It is the qualified beneficiaries responsibility to obtain this disability determination from the Social Security Administration and provide a copy of the determination to the Plan Administrator according to the below listed notification procedures within 60 calendar days after the date of determination and before the original 18 months expire. In general, if coverage is extended due to a Social Security Disability, premium rates may be raised to 150% of the applicable rate

Secondary Event Extension - Another extension of the 18 or above mentioned 29 month continuation period can occur, if during the 18 or 29 months of continuation coverage, a second qualifying event takes place such as a divorce, legal separation, death, Medicare entitlement, or a dependent child ceasing to be a dependent. If a second event occurs, during the original 18 or 29 months of continuation coverage, coverage will be extended to 36 months from the date of the original qualifying event date for eligible dependent qualified beneficiaries. It is the qualified beneficiaries responsibility to notify Maricopa County according to the below listed notification procedures within 60 calendar days of the second event and within the original 18 or 29 month continuation timeline. In no event, however, will continuation coverage last beyond three years from the date of the event that originally made the qualified beneficiary eligible for continuation coverage. A reduction in hours followed by a termination of employment is not a second event.

Social Security Disability/Second Qualifying Event Notification Procedures

1. Complete the COBRA Qualifying Event Notification form.
2. Make a copy of the form for your records.
3. Attach the required documentation depending upon the qualifying event.
4. Mail the notification form to the address listed on the form and document your mailing.
5. Call ADP within 10 calendar days to insure the notification form has been received.

Length of Continuation Coverage - 36 Months

If the original event causing the loss of coverage was the death of the employee, divorce, legal separation, Medicare entitlement, or a dependent child ceasing to be a dependent child under the Maricopa County Employee Health Insurance Program, then each dependent qualified beneficiary will have the opportunity to continue coverage for 36 months from the date of the qualifying event.

Eligibility and Premiums

A qualified beneficiary does not have to show they are insurable to elect continuation coverage; however, they must have been covered by the plan on the day before the event to be eligible for continuation coverage. An exception to this rule is if while on continuation coverage a baby is born to or adopted by a covered employee qualified beneficiary. If this occurs, the newborn or adopted child can be added to the plan and will gain the rights of all other qualified beneficiaries. The COBRA timeline for the newborn or adopted child is measured from the date of the original qualifying event. Procedures and timelines for adding these individuals can be found in your Know Your Benefits booklet and must be followed. The Plan Administrator reserves the right to verify continuation eligibility status and terminate continuation coverage retroactively if a qualified beneficiary is determined to be ineligible or if there has been a material misrepresentation of the facts.

A qualified beneficiary will have to pay all of the applicable premium plus a 2% administration charge for continuation coverage. These premiums will be adjusted during the continuation period if the applicable premium amount changes. In addition, if continuation coverage is extended from 18 months to 29 months due to a Social Security disability, Maricopa County can charge up to 150% of the applicable premium during the extended coverage period. Qualified beneficiaries will be allowed to pay on a monthly basis. In addition there will be a maximum grace period of 31 calendar days for the regularly scheduled monthly premiums.

Cancellation of Continuation Coverage

The law provides that if elected and paid for, your continuation coverage <u>will end prior</u> to the maximum continuation period for any of the following reasons:

1. Maricopa County ceases to provide any group health plan to any of its employees;
2. Any required premium for continuation coverage is not paid in a timely manner;
3. A qualified beneficiary first becomes, after the date of COBRA election, covered under another group health plan that does not contain any exclusion or limitation with respect to any preexisting condition of such beneficiary other than such an exclusion or limitation which does not apply to or is satisfied by such beneficiary by reason of the Health Insurance Portability and Accountability Act;
4. A qualified beneficiary first becomes, after the date of COBRA election, entitled to Medicare;
5. A qualified beneficiary extended continuation coverage to 29 months due to a Social Security disability and a final determination has been made that the qualified beneficiary is no longer disabled;
6. A qualified beneficiary notifies the Plan Administrator he/she wishes to cancel continuation coverage.
7. For cause, on the same basis that the plan terminates the coverage of similarly situated non COBRA participants.

Should continuation coverage be terminated for one of the above reasons, a notice will be sent to you at that time.

Notification of Address Change

In order to protect your group health insurance continuation coverage rights and to insure all covered individuals receive information properly and efficiently, you are required to notify the Plan Administrator of any address change as soon as possible. Failure on your part to do so will result in delayed notifications or a loss of continuation coverage options.

Any Questions?

Remember, this notice is simply a summary of your potential future continuation coverage options and not a description of your actual health benefits under the plan. For questions regarding your health benefits, you should either review the Plan Descriptions or get a copy of the Plan Description from the Plan Administrator. Should an actual qualifying event occur and it is determined that you are eligible for continuation, you will be notified of all your actual rights at that time. Should you have any questions regarding the information contained in this notice, you should contact the Maricopa County EB Division, or you may contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's Web site at **www.dol.gov/ebsa**.

The American Recovery and Reinvestment Act of 2009 (ARRA)

The American Recovery and Reinvestment Act of 2009 (ARRA) as amended by the Department of Defense Appropriations Act (2010 DOD Act) on December 19, 2009, the Temporary Extension Act of 2010 (TEA) on March 2, 2010, and the Continuing Extension Act of 2010, provides for premium reductions for health benefits under COBRA. Eligible individuals pay 35 percent of their COBRA premiums; the remaining 65 percent is reimbursed to the coverage provider through a tax credit. The premium reduction applies to periods of health coverage that began on or after February 17, 2009 and lasts for up to 15 months.

To qualify, individuals must experience a COBRA qualifying event that is the involuntary termination of a covered employee's employment. The involuntary termination must generally occur during the period that began September 1, 2008 and ends on May 31, 2010. However, TEA also provides that an involuntary termination of employment is a qualifying event for purposes of ARRA if the involuntary termination:

- occurs on or after March 2, 2010 and no later than March 31, 2010; and
- follows a qualifying event that was a reduction of hours that occurred at any time from September 1, 2008 through March 31, 2010.

Income Limits

If an individual's modified adjusted gross income for the tax year in which the premium assistance is received exceeds $145,000 (or $290,000 for joint filers), then the amount of the premium reduction during the tax year must be repaid. For taxpayers with adjusted gross income between $125,000 and $145,000 (or $250,000 and $290,000 for joint filers), the amount of the premium reduction that must be repaid is reduced proportionately. Individuals may permanently waive the right to premium reduction but may not later obtain the premium reduction if their adjusted gross incomes end up below the limits. If you think that your income may exceed the amounts above, consult your tax preparer or contact the IRS at www.irs.gov.

Women's Health and Cancer Rights Act (WHCRA)

The federal law known as the Women's Health and Cancer Rights Act was signed into law in 1988 (Public Law 105-227). This law mandates certain benefits for women who elect to have breast reconstruction in connection with a mastectomy. Any plan that provides medical and surgical benefits for a mastectomy must include the following benefits:

1. Reconstruction of the breast on which the mastectomy was performed;
2. Surgery and reconstruction of the other breast to produce a symmetrical appearance;
3. Prostheses; and
4. Treatment of physical complications at all stages of the mastectomy, including lymphedemas.

These benefits must be provided as determined by consultation between the attending physician and the patient. Benefits may be subject to the same deductible and co-insurance provisions that would apply to comparable benefits.

Obtaining a Certificate of Creditable Coverage Under This Plan

Upon loss of coverage under the Medical Plan, a Certificate of Creditable Coverage will be mailed to each terminating individual at the last address on file. You or your dependent may also request a Certificate of Creditable Coverage, without charge, at any time while enrolled in the Medical Plan and for 24 months following termination of coverage. You may need this document as evidence of your prior coverage to reduce any pre-existing condition limitation period under another plan, to help you get special enrollment in another plan, or to obtain certain types of individual health coverage even if you have health problems. To obtain a Certificate of Creditable Coverage, contact CIGNA Customer Service. ADP also provides Certificates of Creditable Coverage and may also be contacted to request a replacement copy.

General Notice of the Plan's Pre-existing Condition Exclusion

The Open Access Plus In-Network plan, the Open Access Plus High and Low plans, and the Choice Fund Health Savings Account plan impose a pre-existing condition exclusion. This means that if you have a medical condition before coming to our plan, you might have to wait a certain period of time before the plan will provide coverage for that condition. This exclusion applies only to conditions for which medical advice, diagnosis, care, or treatment was recommended or received within 90 calendar days prior to your effective date of coverage. The pre-existing condition exclusion does not apply to pregnancy or to a child who is enrolled in the plan within 30 calendar days after birth, adoption, or placement for adoption.

This exclusion may last up to 12 months from your first day of coverage. However, you can reduce the length of this exclusion period by the number of days of your prior "creditable coverage."

- Most prior health coverage is creditable coverage and can be used to reduce the pre-existing condition exclusion if you have not experienced a break in coverage of at least 63 days.
- To reduce the 12-month exclusion period by your creditable coverage, you should provide CIGNA with a copy of any Certificates of Creditable Coverage you have.
- If you do not have a Certificate, but you did have prior health coverage, you should contact your prior plan and ask them for a Certificate of Creditable Coverage. Please contact the EB Division at (602) 506-1010 if you need help demonstrating creditable coverage.

Notice of Special Enrollment Rights

In general, IRS restrictions prevent you from making changes to your coverage elections during the plan year. This means that once you make your health plan elections at Open Enrollment, you may not drop dependents or change your coverage until the next Open Enrollment period. You may be able to add or drop dependents during the plan year (but not change your plan elections) if you experience and report a life event, also known as a qualified status change. These changes include the following:

- You get married or divorced.
- You acquire a dependent child through birth, adoption or placement for adoption.

- Your spouse or dependent dies.
- Your dependent no longer meets the plan's eligibility requirements.
- Your spouse terminates employment or begins new employment.
- You or your spouse change from part-time work to full-time work (or vice-versa).
- You or your spouse has a significant change in health care coverage.
- You are required to provide dependent medical coverage as a result of a valid court decree that meets the requirements of a Qualified Medical Child Support Order (QMCSO).
- Beginning April 1, 2009, you or your dependent's Medicaid or SCHIP coverage is terminated as a result of loss of eligibility. (An employee must be given at least 60 days after the date of termination of the coverage to request special enrollment.)
- Beginning April 1, 2009, you or your dependent becomes eligible for a state premium assistance subsidy under the plan from Medicaid or SCHIP. (An employee must be given a period of at least 60 days after the date on which eligibility for premium assistance has been determined to request special enrollment.)

Any benefit enrollment change you make must be consistent with your qualified status change. To change your coverage, you must complete the status change form within 30 calendar days (or 60 days as noted above) of the date you experience the status change. Your new elections will be effective on either the date of your status change or the date your status change was processed, and retroactive payroll deductions may be withheld. If you do not complete your status change form and deliver it to the EB Division within the 30 calendar day (or 60 days as noted above) period, you must wait until the next Open Enrollment period to change your benefits.

Medicare Secondary Payer Mandatory Insurer Reporting Requirements of Sect 111 of the Medicare, Medicaid, and SCHIP Extension Act of 2007 (P.L. 108-173 42 U.S.C. § 1395y(b)(7))

This law requires the collection and reporting of the Social Security Number (or Medicare Health Insurance Claim Number "HICN") from active covered individuals. Active covered individuals are:

(1) employees and covered family members age 55 (45 as of January 1, 2011) to 64,
(2) employees and covered spouses age 65 and older,
(3) employees and covered dependents who receive kidney dialysis or have had a kidney transplant, and
(4) any covered individual that the plan sponsor knows to be entitled to Medicare.

Genetic Information Nondiscrimination Act (GINA)

Under a federal law, group health plans are prohibited from adjusting premiums or contribution amounts for a group on the basis of genetic information. A health plan is also prohibited from requiring an individual or his/her family member to undergo a genetic test, although the plan may request that a voluntary test be taken for research purposes.

The Heroes Earnings Assistance and Relief Tax Act (HEART)

The HEART amended the Internal Revenue Code Section 125 to allow employers to provide qualified reservist distributions (QRDs) from health flexible spending accounts (FSAs) to employee-reservists who are called to active duty for 180 or more days, or for an indefinite period of time. A QRD is a distribution of all or a portion of the balance in an employee's account that is requested during the period that begins on

the date of the call up and ends on the last date that the reimbursement could otherwise be made under the health FSA for the plan year. These distributions may be made after June 17, 2008.

Notice of Medicaid or Children's Health Insurance Program (CHIP) Offer of Free or Low-cost Health Coverage to Children and Families

If you are eligible for employment-based health coverage from Maricopa County, but are unable to afford the premiums, the State of Arizona may provide a premium assistance program that can help pay for coverage. The State may use funds from its Medicaid or CHIP programs to help people who are eligible for employer-sponsored health coverage, but need assistance in paying their health premiums. If you or your dependents are already enrolled in Arizona's Medicaid (AHCCCS) or CHIP (KidsCare) programs, you can contact the State's Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid (AHCCCS) or CHIP (KidsCare), and you think you or any of your dependents might be eligible for either of these programs, you may contact the Arizona Medicaid or CHIP office at **http://www.azahcccs.gov/applicants/default.aspx**, or call 602-417-5422. You may also dial 1-877-KIDS-NOW or **www.insurekidsnow.gov** to find out how to apply. If you qualify, you can ask if Arizona has a program that might help you pay the premiums for an employer-sponsored plan.

Once it is determined that you or your dependents are eligible for premium assistance under Medicaid or CHIP, your employer's health plan is required to permit you and your dependents to enroll in the plan – as long as you and your dependents are eligible, but not already enrolled in the employer's plan. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance.

For more information on special enrollment rights, you can contact the following federal agencies:

U.S. Department of Labor
Employee Benefits Security Administration
www.dol.gov/ebsa
1-866-444-EBSA (3272)

U.S. Department of Health and Human Services
Centers for Medicare & Medicaid Services
www.cms.hhs.gov
1-877-267-2323, Ext. 61565

Mental Health Parity and Addiction Equity Act of 2008

Under a Federal law known as the Health Insurance Portability and Accountability Act of 1996, Public Law 104-191, as amended ("HIPAA"), group health plans must generally comply with the requirement listed below. However, the law also permits local governmental employers that sponsor health plans to elect to exempt a plan from these requirements for any part of the plan that is "self-funded" by the employer, rather than provided through a health insurance policy. Maricopa County has elected to exempt the Maricopa County Accident and Health Insurance Premium Plan (Second Amendment and Restatement) from the following requirement:

Parity in the application of certain limits to mental health benefits. Group health plans (of employers that employ more than 50 employees) that provide both medical and surgical benefits and mental health or substance use disorder benefits must ensure that financial requirements and treatment limitations applicable to mental health or substance use disorder benefits are no more restrictive than the predominant financial requirements and treatment limitations applicable to substantially all medical and surgical benefits covered by the plan.

The exemption from these Federal requirements will be in effect for the 2010-11 plan year, beginning July 1, 2010 and ending June 30, 2011. The election may be renewed for subsequent plan years.

HIPAA also requires the Plan to provide covered employees and dependents with a "certificate of creditable coverage" when they cease to be covered under the Plan. There is no exemption from this requirement. The certificate provides evidence that you were covered under this Plan, because if you can establish your prior coverage, you may be entitled to certain rights to reduce or eliminate a preexisting condition exclusion if you join another employer's health plan, or if you wish to purchase an individual health insurance policy.

Who To Contact

Maricopa County Employee Benefits Division
Maricopa County Chambers Building
301 South 4th Avenue, Suite B100
Phoenix, Arizona 85003-2145

Phone: (602) 506-1010 ~ **Fax:** (602) 506-2354
TTY: (602) 506-1908

www.maricopa.gov/benefits ~ http://ebc.maricopa.gov/ehi
BenefitsService@mail.maricopa.gov

Maricopa County Wellness Works

Phone: (602) 506-3758 ~ **Fax:** (602) 506-1292

Employee_Wellness@mail.maricopa.gov

Medical Plans

CIGNA - *Group #3205496*
Customer Service - (800) 244-6224
Pre-Enrollment Questions - (800) 401-4041
24-Hour Health Information Line - (800) 564-8982
HSA Banking Unit Customer Service Line - (866) 524-2483
Well Aware Disease Management - (800) 249-6512 to enroll
or (877) 888-3091 for questions
Healthy Pregnancies, Healthy Babies - (800) 615-2906
Healthy Rewards - (800) 870-3470
www.cigna.com
www.mycigna.com
www.mycignaplans.com
(username: Maricopa2010 / password:cigna)
www.cigna.com/cmgaz

Pharmacy Plans

Walgreens Health Initiatives - *Group #512229*
Member Services - (800) 207-2568
Prior Authorization - (877) 665-6609
Walgreens Mail Service Member Service - (888) 265-1953
Mail Service Refills - (800) 797-3345
Specialty Pharmacy - (888) 782-8443
Medication Therapy Management - (866) 352-5310
www.mywhi.com

CIGNA Pharmacy Plan *(Choice Fund Medical Plan only)* - Group #3205496
(800) 244-6224

CIGNA Tel-Drug Mail Service - (800) TEL-DRUG

Behavioral Health

Magellan Health Services - *Group# N/A*
(888) 213-5125
www.magellanhealth.com

CIGNA Behavioral Health *(Choice Fund Medical Plan only)* - *Group #3205496*
(800) 244-6224
www.cignabehavioral.com

EAP

Magellan Health Services - *Group# N/A*
(888) 213-5125
www.magellanhealth.com

Vision

EyeMed Vision Care - *Group# 9750076-Comprehensive Eye Exam; 9750092-LASIK; 9750118-Acute Care*
Customer Service - (866) 723-0514
Pre-Enrollment Questions - (866) 299-1358
LASIK - (877) 5LASER6
www.eyemedvisioncare.com

Dental

Employers Dental Services - *Group #11931-Plan #300R*
(602) 248-8912 or (800) 722-9772
www.mydentalplan.net

CIGNA Dental - *Group # 2465354*
(888) 336-8258
www.mycigna.com

Delta Dental - *Group # 4500*
(602) 938-3131 or (800) 352-6132
www.deltadentalaz.com

Life Insurance

The Standard - Policy #645547
(888) 414-0396
www.standard.com/mybenefits/maricopa

Short-Term and Long-Term Disability

Sedgwick CMS - Group# 435000
Short Term Disability - (800) 599-7797
Long Term Disability - (800) 495-9301
www.sedgwickcms.com/calabasas

Retirement

Arizona State Retirement System - (602) 240-2000
Outside Phoenix - (800) 621-3778
www.azasrs.gov/web/index.do

Public Safety Retirement System
(602) 255-5575
www.psprs.com

Nationwide Retirement Solutions:
Deferred Compensation
(602) 266-2733
(800) 598-4457
www.maricopadc.com

Other

Automatic Data Processing, Inc. (ADP) Flexible Spending Accounts
(800) 654-6695
Claims & Substantiation Fax: (866) 392-4090
Activate Debit Card (877) 368-7517
www.flexdirect.adp.com

COBRA Administrator
(800) 770-7981
Call for applicable fax number
https://www.benedirect.adp.com

Maricopa County Dependent Audit Service Center
ADP - DAS
PO Box 2338
Alpharetta, GA 30023-2338
(800) 553-3823
Fax: (866) 400-1686

Liberty Mutual: - Group #8871
Auto, Home and Renters Insurance
(800) 221-8135
www.libertymutual.com/lm/maricopacountyemployees

MetLaw® Hyatt Legal Plans- *Plan 150 / Group #0518*
(800) 821-6400
www.info.legalplans.com *(password - 1500518)*

Biometric Screening Administrator CIGNA Onsite
(800) 694-4982
https://www.cignascreenings.com/maricopa

Health Assessment Technical Assistance
(800) 853-2713
www.mycigna.com